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CITY AND COUNTY OF SAN FRANCISCO

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,

Plaintiff,

vs.

ALEX M. AZAR II, et al.,

Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,

Plaintiff,

vs.

ALEX M. AZAR, et al.,

Defendants.

COUNTY OF SANTA CLARA et al,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

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

DECLARATION OF CHRISTINE SIADOR IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date: October 30, 2019
Time: 8:00 AM
Courtroom: 12
Judge: Hon. William H. Alsup
Action Filed: 5/2/2019

I, Christine Siador, declare as follows:

1. I have personal knowledge of the facts set forth in this declaration and, if called as a witness, could and would testify competently to the matters set forth below.

2. I am the Deputy Director of the Population Health Division and the Director of the Office of Operations, Finance & Grants Management in the San Francisco Department of Public Health ("SFDPH").

3. The SFDPH Population Health Division ("PHD") receives approximately $2.5 million in federal funding from the U.S. Department of Health and Human Services ("HHS") for public health research including randomized clinical trials focused on HIV and substance use.

4. For example, PHD's HIV research unit, Bridge HIV—which has been at the vanguard of HIV prevention science since the beginning of the HIV epidemic and is a recognized global leader in HIV prevention research—is 100% grant funded, primarily through the HHS National Institutes of Health ("NIH").

5. Bridge HIV's work touches HIV prevention efforts at the highest levels; national health entities, such as the Centers for Disease Control and Prevention ("CDC") draw upon the data that comes from its trials to create guidelines to stop the spread of HIV. Bridge HIV provides evidence that directly informs public health practice decisions. For example, Bridge HIV participated in the landmark trial that demonstrated the safety and efficacy of using antiretroviral medicine for HIV prevention in healthy people who are at risk of HIV infections. This prevention strategy is known as pre-exposure prophylaxis ("PrEP"). PrEP has changed the landscape of HIV prevention. In fact, the Getting to Zero San Francisco Consortium has adopted PrEP as one of the key strategies to achieve its immediate goal of reducing both HIV infections and HIV deaths by 90% from their 2013 levels by the year 2020.

6. None of this would have been possible without funding from HHS—and future life-saving breakthroughs will be jeopardized if these funds are terminated.

7. Similarly, SFDPH's Disease Prevention and Control Branch ("DPC") oversees public health clinical, laboratory and disease intervention services. It performs many of the legally mandated activities intended to protect public health and therefore serves everyone in San

Francisco. This Branch is also responsible for informing and guiding San Francisco clinicians in best practices for communicable and chronic disease prevention and is a resource for expert clinical and laboratory consultation, including control and treatment of communicable diseases during outbreaks. Within SFDPH, DPC staff work closely with the San Francisco Health Network to optimize clinical policies and care in the DPC core areas. In addition, DPC staff work with clinical providers and systems throughout San Francisco to improve prevention, diagnosis, and treatment of communicable diseases using a public health detailing model of engagement.

8. DPC currently receives over $15 million in funding from the CDC. Losing these funds would impact all aspects of the Branch's work and threaten San Francisco's ability to detect, treat, and prevent diseases such as HIV, STDs, TB, Hepatitis C and other communicable diseases—putting hundreds of thousands of people at higher risk for illness.

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on September 9, at San Francisco, California.

Christine Siador

Christine Siador

JAMES R. WILLIAMS, County Counsel (SBN 271253)
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Counsel for Plaintiffs

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA, et al.,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

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

DECLARATION OF NARINDER SINGH, Pharm. D., DIRECTOR OF PHARMACY FOR THE COUNTY OF SANTA CLARA, IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date:	October 30, 2019
Time:	8:00 AM
Courtroom:	12
Judge:	Hon. William H. Alsup
Action Filed:	5/2/2019

I, NARINDER SINGH, Pharm. D., declare:

1. I am a resident of the State of California. I submit this declaration in support of the County of Santa Clara's ("County"), and its co-plaintiffs', Motion for Summary Judgment. I am over the age of 18 and have personal knowledge of all the facts stated herein. If called as a witness, I could and would testify competently to all the matters set forth below.

2. I am the Director of Pharmacy for the County. I have held this position since October of 2003. Prior to my current role, I served as the Director of Pharmacy at the University of Southern California. In my current role as Directory of Pharmacy for the County, I am responsible for medication management across the County, overseeing creation of our formulary, and overseeing all pharmacy staff. The County's Pharmacy Department ("Pharmacy Department") employs around 405 pharmacy staff, including technicians and assistants.

3. The Pharmacy Department operates twelve pharmacies throughout the County of Santa Clara Health and Hospitals System. Patients can pick up their prescriptions at these pharmacies, and our pharmacy staff also provide medications prescribed to admitted patients.

4. The Pharmacy Department operates two of its twelve pharmacy locations under the umbrella of the County Public Health Department. One of these pharmacies provides free, donated medicine to individuals who cannot afford the retail cost of such drugs. The other pharmacy specializes in serving patients with HIV/AIDS, patients with tuberculosis, patients from the Public Health Department's STD clinic, and patients being discharged from the County jail.

5. The Pharmacy Department staff support communicable disease control by procuring, storing, maintaining, and distributing essential medications and vaccines during outbreaks; and distributing approximately 20,000 state-funded influenza vaccines, annually, to healthcare providers in Santa Clara County to administer to low-income and elderly residents at no charge. The pharmacies associated with the Public Health Department also oversee all enrollment workers in Santa Clara County for the state-sponsored AIDS Drug Assistance Program, which serves low-income HIV/AIDS patients. In addition, the Pharmacy Department staff support the County's emergency preparedness program should there be a need for mass

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prophylaxis or rapid response to a chemical incident. We also have a central fill location at which we receive and sort medication for distribution to our other twelve locations.

6. The Pharmacy Department fills prescriptions for a variety of medications, including prescriptions for hormonal replacement therapy for transgender people, medication for chemical castration, emergency and oral contraceptives, and the medication for a medical abortion. At some of our pharmacies, there is only one pharmacist on site at any given time.

7. We recognize that situations may arise in which appropriate patient care conflicts with a pharmacist's cultural values, ethics, or religious beliefs. Accordingly, the County has a policy allowing its current and prospective medical-staff members and employees to request in writing not to participate in certain patient care that conflicts with the staff member's cultural values, ethics, or religious beliefs. Pharmacists are covered by this policy. A copy of the policy is attached to the Declaration of Paul Lorenz as **Exhibit A**.

8. I understand that pharmacists are required by California regulations to provide a patient consultation for any new prescription or changes in existing prescriptions unless the patient refuses the pharmacist consultation. If a pharmacist employed by the County fails to offer a consultation to a patient, the State Board of Pharmacy could levy fines against the County.

9. In the past, a pharmacist voiced an objection to dispensing emergency contraception to patients. To accommodate the objection, if that pharmacist was working shifts where there were multiple pharmacists, the pharmacist would refrain from dispensing emergency contraceptive medication and request that other pharmacists do so instead. If that pharmacist was the only pharmacist on duty, they would call another Pharmacy Department location and request that another pharmacist perform the required patient consultation over the phone. Eventually, that pharmacist was assigned to different position in the Pharmacy Department where they would not be charged with providing care that they objected to.

10. Had this pharmacist declined to provide or connect a patient with a consultation, the Pharmacy Department could have been subject to State fines for noncompliance with patient consultation requirements. Further, because sometimes only one pharmacist is on site, advance notice of and planning for religious objections is critical to ensuring that patients can obtain their

prescribed medications even if the pharmacist on duty objects to providing certain types of medication, providing medication for certain uses, or serving certain groups of people. If patients encounter obstacles to obtaining prescribed medication due to a pharmacist's personal objections, they may be discouraged from, delayed in, or prevented from obtaining necessary medication. And if the need for a medication is time sensitive, the patient may suffer adverse impacts or lose out on the opportunity to access specific care. For example, a delay in obtaining emergency contraception may result in unplanned pregnancy and the lifelong consequences that flow from it.

11. We also rely on certain pharmacists to review new drugs to be added to the County formulary, or the lists of drugs that can be prescribed by County providers. If those specific pharmacists declined to review medications they objected to on religious or ethical grounds to the County's formulary, it would be impossible to order those drugs throughout the entire system until someone else added the drugs. It takes months to train someone to be able to review new drugs for the formulary, and if we were not promptly informed of a pharmacist's objection to adding a drug to our system, it could greatly delay patient and provider access to necessary medication. Further, if we could not ensure that a pharmacist was comfortable with writing the clinical monographs necessary for formulary review before hiring them to work on formularies, this could create inefficiencies and delay the issuance of proper formularies. Similarly, if a staff member in charge of purchasing medications declined to order a drug based on an ethical or religious objection without informing us, it would delay patient access to medication as we would only discover this had been done once we ran out of medication.

12. The Pharmacy Department also employs technicians and assistants to perform nonclinical activities, such as delivering drugs or directly handing drugs to patients being discharged or currently being treated in the Emergency Department. Were a technician or assistant to elect not to take drugs to a patient due to a religious or moral objection, this would delay patient access to necessary medication. This would be particularly problematic if the technician or assistant did not inform anyone that they had not delivered the drug and could create a highly dangerous situation in which a pharmacist was unaware that a patient had not received their prescribed medication.

13. Additionally, pharmacists work closely with doctors during clinical interventions. During these interventions, doctors may request information regarding a specific drug from the pharmacist. If a pharmacist had a moral or ethical objection to the type of care being provided or the drug being requested, they could refuse to assist the doctor or not provide the requested information. If the doctor was not made aware of the pharmacists' objection, they may not realize that information necessary to provide adequate patient care may have been withheld.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on 9/6, 2019 in San José, California.

NARINDER SINGH, Pharm. D.
Director of Pharmacy

JAMES R. WILLIAMS, County Counsel (SBN 271253)
GRETA S. HANSEN (SBN 251471)
LAURA S. TRICE (SBN 284837)
MARY E. HANNA-WEIR (SBN 320011)
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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA, et al.,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

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

DECLARATION OF JILL SPROUL, R.N., CHIEF NURSING OFFICER OF SANTA CLARA VALLEY MEDICAL CENTER, IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date:	October 30, 2019
Time:	8:00 AM
Courtroom:	12
Judge:	Hon. William H. Alsup
Action Filed:	5/2/2019

I, JILL SPROUL, R.N., declare:

1. I am a resident of the State of California. I submit this declaration in support of the County of Santa Clara's ("County"), and its co-plaintiffs', Motion for Summary Judgment. I am over the age of 18 and have personal knowledge of all the facts stated herein. If called as a witness, I could and would testify competently to all the matters set forth below.

2. I am the Chief Nursing Officer for all of the hospitals and clinics operated by the County of Santa Clara ("County"), including Santa Clara Valley Medical Center ("Valley Medical Center"), O'Connor Hospital, and St. Louise Hospital.[1] Prior to my current role, I served as Nurse Manager for Valley Medical Center's Burn Center and as Valley Medical Center's Interim Director of Critical Care. I have served in public health care for 29 years.

3. The County employs approximately 3,000 nurses. In my role as Chief Nursing Officer, I am responsible for overseeing staffing of nurses, defining the scope of nurse practice at the County's three hospitals, and establishing policies and standards that govern how nurses carry out their duties and are supervised.

4. The County recognizes that situations may arise in which appropriate patient care conflicts with a nurse's cultural values, ethics, or religious beliefs. Accordingly, the County has a policy allowing its current and prospective medical-staff members and employees to request in writing not to participate in certain patient care that conflicts with the staff member's cultural values, ethics, or religious beliefs. A copy of the policy is attached to the Declaration of Paul Lorenz as Exhibit A.

5. The policy provides that once an exemption is requested, the appropriate manager or director determines whether the request can be granted in light of staffing levels and other relevant circumstances. If the request is granted, the staff member's tasks, activities, and duties may be redistributed to ensure appropriate patient care.

[1] The County only recently acquired O'Connor and St. Louise hospitals, so my knowledge of the historical practice of those hospitals is limited. I do know, however, that the County Health System is in the process of integrating policies across all three hospitals and plans to adopt the religious objection policies in place for Valley Medical Center or substantially similar versions enterprise-wide.

6. The policy makes clear that a request for an exemption will not result in disciplinary or recriminatory action. However, a manager or director may decline to accept an employee or medical staff member for permanent assignment when the employee/medical staff member has requested not to participate in an aspect of care that is commonly performed in that assignment. The policy also makes clear that patient care may not be adversely affected by the granting of an exemption and that medical emergencies take precedence over personal beliefs.

7. Before we adopted this policy in 2017, we had in place a Nursing Standard, which applied to religious objections to abortions. That Nursing Standard similarly provided that a nurse could submit a request not to participate in medical procedures that resulted in abortions, but also provided that a nurse would still have to participate in such procedures in the event of an emergency until relief personnel could take over the nurse's responsibilities. A copy of that standard is attached as **Exhibit A**.

8. Objections to participation in patient care on moral, ethical, or religious grounds are also addressed in the Memorandum of Agreement ("MOA") between the County and the Registered Nurses Professional Association, the exclusive bargaining representative for nurses at the County's three hospitals. Section 18.2 of that MOA—like Valley Medical Center's policy—recognizes that while nurses must generally be free to refuse to provide care based on their moral, ethical, or religious beliefs without threat of discipline, in an emergency a nurse must provide necessary care until other personnel can take over. Under such circumstances, our nurses have agreed that a patient's right to receive necessary nursing care takes precedence over the exercise of a nurse's individual beliefs. A copy of the Memorandum of Agreement is attached as **Exhibit B**.

9. Nurses sometimes object to providing certain types of care, including assisting in organ donation procedures or in terminating pregnancies. In those situations, prior notice of conscience objections has allowed us to make staffing plans to ensure that a nurse's moral or religious objection can be accommodated without compromising patient care. Currently, twenty-seven nurses in our Operating Room Department have objections to participating in abortions on file. We also regularly honor informal objections that are raised to managers. Because we are

aware of our nurses' objections, we are able to accommodate them by assigning other nurses to perform the patient care to which they object.

10. Our nurses' willingness to provide care in emergency situations is critical to ensuring patient safety. Valley Medical Center includes a Level I trauma center equipped to provide the highest level of comprehensive care to patients suffering from life-threatening traumatic injuries. There, nurses are part of teams that treat people who are in serious medical crisis, such as situations where a patient is bleeding out or has experienced severe burns. Further, other healthcare needs may also not initially present as emergent but may become so. For example, while most abortion procedures can be scheduled in advance, sometimes patients scheduled for routine obstetric care may develop an unexpected medical need for an abortion, which can be provided in an outpatient, ambulatory setting if caught quickly. Were a nurse to abandon or refuse to treat a patient during a time-sensitive emergency, patient care and safety would be seriously compromised.

11. As Chief Nursing Officer, I constantly deal with staffing challenges. Night shifts, holiday periods, and flu season are all especially challenging times from a staffing perspective, and it can be difficult to fill shifts during these periods. Were a nurse to unexpectedly object to providing care, there might be no other nurse to take over their responsibilities in a timely manner, which would undermine patient care and could even be life threating in an emergency situation. Even if there were another nurse available, abruptly changing nurse assignments would disrupt our nurses' work flow and result in additional patient hand-offs when a non-objecting nurse takes over mid-shift. Medical research reflects that inadequate handoffs of patients can pose dangers to patient health. Patient care and safety would also be put at risk if a nurse decided not to assist a patient on moral, ethical, or religious grounds and failed to provide notice to other staff, because the rest of the medical team might not immediately be aware that the nurse had declined to assist the patient and care might be delayed.

12. Additionally, it is critical that the County be able to match our nurses with jobs or schedules that are consistent with their moral, ethical, or religious objections. If a nurse objected to care regularly provided in his or her assignment but declined reassignment, this would cause

repeated staffing challenges and might regularly undermine patient care. If the County lacked the ability to take objections into account when setting nurse schedules, or if nurses could unilaterally reject any schedule or assignment set to accommodate their religious objections, patient care could be disrupted, and we could face short staffing for certain medical procedures.

13. Our hospital regularly serves vulnerable patients from a variety of backgrounds, including LGBTQ patients. Were a nurse to refuse treatment to a patient based solely on the patient's identity, it would harm that patient's trust in our hospitals and undermine the County's mission to provide healthcare to vulnerable populations.

14. As a safety-net provider, we are often the last resort or only option for patients with limited healthcare options, such as those who are uninsured or underinsured. If those patients are turned away from our hospitals, they may have no other options to address their healthcare needs.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

Executed on September 10, 2019 in San José, California.

Jill L. Sproul, RN

JILL SPROUL, R.N.
Chief Nursing Officer

EXHIBIT A

ABORTION PROCEDURE, EMPLOYEE OBJECTION TO PARTICIPATION IN ELECTIVE

I. POLICY

Nursing personnel who object to participating in an elective abortion procedure on moral, ethical, or religious grounds shall not be required to participate in the specific medical procedures which result in an abortion, except in cases of medical emergencies or spontaneous abortions.

II. PURPOSE

To comply with Health and Safety Code Division 106, Part 2, Chapter 2, §123420 and JCAHO Standards which protect a medical employee's right to refrain from participating in medical procedures that conflict with that employee's ethics, religious beliefs, or cultural values.

III. PROCESS

A. A member of the nursing staff who objects to abortions on moral, ethical, or religious grounds shall state so in writing by completing and signing a form entitled "Employee Statement regarding Abortion." (see page 2) These forms are kept in the Nursing Office. The nursing staff member should allow two weeks after submitting this form for processing of his/her request

B. Once a member of the nursing staff who has submitted an Employee Statement regarding Abortion has received approval of his or her request, that employee shall not be required to participate in the specific medical procedures which result in abortions (except in cases of medical emergencies or spontaneous abortions), and the refusal by such an employee to do so shall not result in any disciplinary action, denial of privileges, or any other penalty.

C. Specific nursing service areas where abortions are commonly performed may refuse to accept permanently assigned staff who object to participate in abortion procedures.

D. Because SCVMC is obligated to treat all emergencies, medical emergencies or spontaneous abortions must take precedence over personal beliefs, such as those of nursing staff members who have submitted Employee Statements regarding Abortion.

E. Should a need arise where a nursing staff member who has signed the Employee Statement regarding Abortion is called upon to care for the patient during a medical emergency relating to abortion or during a spontaneous abortion, the nursing staff member must do so promptly until relief personnel arrive to take his or her place. Relief personnel will be provided as soon as possible.

IV. ATTACHMENT

Employee Statement Regarding Abortion form.

References: Administration Policies and Procedure VMC#132.01 "Non-Participation in Certain Patient Care".

History: Original 10/81; **Revised** 9/84, 11/89 5/91, 7/95 (A-6903-108), 3/97, 2/02, 7/07; **Reviewed** 5/88, 5/93, 6/98, 8/01, 1/05, 6/10 **Deleted** 5/2014

SANTA CLARA VALLEY MEDICAL CENTER
DEPARTMENT OF NURSING SERVICE

EMPLOYEE STATEMENT REGARDING ABORTION

I the undersigned, an employee (or prospective employee) of the Santa Clara Valley Medical Center, request that during the course of my employment at the Medical Center I not be assigned to duties involving direct participation in the initiation, induction, or performance of an abortion on a patient in this hospital.

This statement is made because of my moral, ethical or religious beliefs relating to such procedures.

I understand that medical emergency situations or spontaneous abortions take precedence over personal beliefs, and that if I am called upon to assist in such cases, I will do so promptly until such time when other qualified personnel will be provided to relieve me. I understand that qualified personnel will be provided as soon as possible.

Date _____

Time_____

_____ _____

Signature Witness

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA et al,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C 19-02405 WHA
No. C 19-02769 WHA
No. C 19-02916 WHA

DECLARATION OF JAY STURGES IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date:	October 30, 2019
Time:	8:00 AM
Courtroom:	12
Judge:	Hon. William H. Alsup
Action Filed:	5/2/2019

I, Jay Sturges, declare:

1. I am the Associate Secretary, Fiscal Policy and Administration, for the California Labor and Workforce Development Agency (LWDA). I serve as the primary advisor to the Agency Secretary on the interpretation, development, evaluation and implementation of Agency-level fiscal policies and for ensuring the fiscal integrity of the departments, boards and panels within the LWDA.

2. The LWDA is an agency in the executive branch, and the Secretary is a member of the Governor's Cabinet. LWDA oversees seven major departments, boards and panels that serve California businesses and workers: the Agricultural Labor Relations Board, the California Employment Development Department, the California Public Employment Relations Board, the California Unemployment Insurance Appeals Board, the California Workforce Development Board, the Department of Industrial Relations, and the Employment Training Panel. LWDA programs and services touch the lives of all members of the state's workforce and their families.

3. I am familiar with the rule Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, RIN 0945-AA10, issued by the U.S. Department of Health and Human Services (HHS) on May 2, 2019, and published in the Federal Register on May 21, 2019 (the Rule).

4. The Rule has already imposed costs on California. LWDA and the departments within the agency have already spent more than 11 hours reading and analyzing the Rule and attempting to determine its potential impacts on our programs and workforce.

5. The Rule jeopardizes federal funds departments within the LWDA receive from the U.S. Department of Labor, if California is determined to violate the Rule. Loss of federal funding will have a deleterious impact on California, the nation's most populous state, by hampering workplace safety, stifling economic development, and harming efforts to assist unemployed individuals. LWDA and the departments and offices it oversees will be unable to absorb such a tremendous loss of funding without a reduction in staffing, programs and services.

6. Federal funding comes to the departments within the LWDA from appropriations acts approved by Congress and signed by the president. The Department of Defense and Labor,

Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019, Public Law 115-245, which was enacted September 28, 2019, makes appropriations for the following programs (among others), which provide funding to the departments within the LWDA:

- Title III of the Social Security Act, (the State Unemployment Insurance Program), to provide payments to laid-off workers;
- The Workforce Innovation and Opportunity Act, including grants to states for adult employment and training activities, youth activities, and dislocated worker employment and training activities;
- The Wagner-Peyser Act of 1933 to establish a nationwide system of public employment offices to assist individuals seeking employment;
- The Occupational Safety and Health Act, section 23(g), to assist states in administering and enforcing programs for occupational safety and health;
- The Jobs for Veterans State grants program under 38 U.S.C. 4102A(b)(5) to support disabled veterans' outreach program specialists; and
- The National Apprenticeship Act to expand apprenticeship and on-the-job training programs.

7. Federal funding supports numerous programs within the LWDA, including dollars that support state operations or are passed through to local workforce development boards. With regard to the programs within LWDA (among others) that are jeopardized by the Rule, the state's 2019-20 Governor's Budget anticipates receiving federal funding in state fiscal year 2018-19 for the following programs:

- The California Employment Development Department provides short-term income replacement for individuals who are unemployed through no fault of their own through the administration of the Unemployment Insurance benefit payment program, allocates funding to local workforce development boards and provides direct services that benefit job seekers and employers statewide ($899.9 million);

- The California Unemployment Insurance Appeals Board conducts impartial hearings and issues decisions to resolve disputed unemployment insurance determinations ($66.5 million);
- The California Workforce Development Board, which collaborates with both state and local partners to establish and continuously improve the state workforce system, with an emphasis on California's economic vitality and growth ($4.8 million);
- The Department of Industrial Relations (DIR), which is responsible for enforcing workers' compensation insurance laws, adjudicating workers' compensation claims, and working to prevent industrial injuries and deaths, as well as promulgating regulations and enforcing laws relating to wages, hours, and conditions of employment, promoting apprenticeship and other on-the-job training, and analyzing and disseminating statistics which measure the condition of labor in the state ($38.3 million);

8. Within DIR, federal funding supports numerous programs and subprograms, including the following:

- The Division of Occupational Safety and Health, which promotes and enforces measures to protect the health and safety of workers on the job and the safe operation of elevators, amusement rides, aerial passenger tramways, and pressure vessels for the benefit of the general public, is authorized through the state budget to receive a total of $36.4 million in federal funding in 2018-19. This supports the Compliance subprogram ($25.9 million), the Mining and Tunneling subprogram ($433,000), the Occupational Safety and Health Appeals Board ($2.3 million), the Occupational Safety and Health Standards Board ($1.2 million), and Consultation Services ($6.6 million);
- The Division of Labor Standards Enforcement, for the Retaliation subprogram ($504,000); and
- The Division of Apprenticeship Standards, to increase the number of apprenticeships in California ($1.4 million).

9. In developing the state's annual budget, the departments within the LWDA did so with the expectation that they would receive the federal funds placed at risk under the Rule, and to which they are entitled to under agreements with federal agencies. A sudden disruption in anticipated federal funds would create budgetary and operational chaos.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed on September 6, 2019 in Sacramento, California.

Jay Sturges
Associate Secretary, Fiscal Policy and Administration
California Labor & Workforce Development Agency

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA et al,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C 19-02405 WHA
No. C 19-02769 WHA
No. C 19-02916 WHA

DECLARATION OF DIANA TOCHE, D.D.S., IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date: October 30, 2019
Time: 8:00 AM
Courtroom: 12
Judge: Hon. William H. Alsup
Action Filed: 5/2/2019

I, Diana Toche, D.D.S., declare:

1. The matters stated in this declaration are true based on my own personal knowledge, except as to those matters stated on information and belief, and as to those matters, I believe them to be true, and if called as a witness, I would competently so testify.

2. I am the Undersecretary for Health Care Services, California Department of Corrections and Rehabilitation (CDCR) and have been serving in this capacity since May 13, 2014. Previously, I served CDCR as the Acting Undersecretary for Administration and Offender Services, Acting Director of the Division of Health Care Services and Deputy Director, Division of Health Care Services, Dental Programs. Some of my current duties as Undersecretary for Health Care Services include directing the management and supervision of medical, mental health, dental and ancillary health care services for inmates under the jurisdiction of CDCR.

3. In conjunction with Clark Kelso, the federal Receiver appointed under the federal class action of *Plata v. Newsom*, I lead California Correctional Health Care Services (CCHCS), the state entity responsible for providing health care services to CDCR's adult prison population. The CCHCS providers and contractors provide medical, dental, and mental health care services to over 125,000 prison inmates in 35 CDCR institutions and contracted facilities. CCHCS has almost 18,000 state civil service positions authorized in Fiscal Year 2018-2019, primarily located at the 35 prisons, at its headquarters in Elk Grove, California, and at CDCR headquarters in Sacramento, California. In addition to state funding, CCHCS is eligible to receive federal Medicaid funds for the inpatient hospitalization of some inmates through the California Department of Health Care Service Medi-Cal program, pursuant to California Penal Code sections 5072 and 2065.

4. I am familiar with the rule, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," RIN 0945-AA10, issued by the U.S. Department of Health and Human Services (the Rule), published in the Federal Register on May 21, 2019.

5. The Rule will impose an immediate cost on CCHCS due to its notice, assurance and certification, recordkeeping, and reporting requirements. The Rule has already imposed costs on CCHCS as CCHCS has been required to spend twenty hours reading and analyzing the Rule,

and attempting to determine its impact on CCHCS programs and whether programmatic changes are necessitated.

6. The Rule allows health care staff and ancillary personnel to refuse to provide care on religious or moral grounds for wide range of services, including but not limited to abortion, sterilization and euthanasia. Objections could apparently also impact providing vaccinations, treatment for gender dysphoria and delivering end-of-life care.

7. CCHCS was established in order for the state to better coordinate its continuing remedial efforts with those of the court-appointed Receiver in the *Plata* case. Inmates in the custody of CDCR are entitled to receive medical, dental and mental health care in a nondiscriminatory and timely manner under both federal and state law. California Penal Code sections 3402 through 3409 mandate services for female inmates, including contraception, birth control and abortion. Under the Eighth and Fourteenth Amendments, CCHCS is obliged to provide transgender inmates with medical and mental health care services. As noted by the Supreme Court in Brown *v. Plata*, 563 U.S. 493 (2011), mental health and medical care in CDCR were determined to fall below Eighth Amendment standards in 1995 and 2001, respectively. Providing timely access to emergency, routine and specialty care and ensuring inmates receive competent, effective services as required for CCHCS and CDCR to comply with the continuing orders of the federal district court cases are key linchpins of CCHCS' efforts.

8. Ensuring there are sufficient numbers of providers, nurses and support staff available to provide inmate care within the California prison system and that they effectively coordinate with community specialty and hospital services are essential components of a constitutionally adequate correctional health care delivery system. In addition, custody and transportation staff must be available and ready to ensure security for in-prison care and especially for off-site services and hospitalizations. The Rule appears to allow a medical provider to deny care for an uncertain range of health services without providing notice or making alternative options available. It is not clear whether objections could be lodged by the correctional staff whose assistance is critical to the delivery of a contested medical service. Having to arrange for substituted provider staff and rescheduling appointments and transportation

will increase risks in the delivery of inmate health care services. Delays by themselves can put CCHCS out of compliance with court orders. Additional staff and contractors will be added to ensure sufficient redundant capabilities are available for unexpected objections to provide care. Modifications to workforce policies regarding the expected performance, procedures for conducting employee investigations and modifications to bargaining unit agreements are anticipated, particularly during the first year of the Rule.

9. The notification provisions of the Rule will impose further costs on CCHCS. Although the Rule indicates that the notice provisions are now voluntary (unlike in the proposed rule), the Rule also states that adherence to the notice provisions will be taken into consideration when assessing whether an agency is in compliance. To provide notice, CCHCS will need to: (1) post the notice in Appendix A (or similar text) at each CCHCS establishment where notices to the public and workforce are customarily posted, and thereafter continuously take steps to ensure that the notice is not altered, defaced, or covered by other materials, (2) include the notice on each of its websites, and (3) include the notice in its personnel manuals, applications, and benefits and training materials, as inclusion in these materials will be a factor in determining whether CCHCS is in compliance. The estimated costs of compliance with these notification provisions is approximately $10,000 due to the necessary changes to websites, physical postings at medical facilities and administrative facilities, as well as costs associated with updates to training manuals, new employee documentation, internship materials, and updates to benefits handbooks.

10. The Rule also includes an assurance and certification requirement that should be included with all applications, reapplications, and amendments and modifications. The provision also places an obligation on CCHCS to take actions to come into compliance. Notably and under the compliance provision, if a sub-recipient (as defined by the Rule) is found in violation, CCHCS will be subject to remedial action. The Rule requires CCHCS to undertake some additional oversight obligations regarding its hundreds of contracted health care providers working both within CDCR institutions and in the community which would require CCHCS to utilize additional staff time to perform this sub-recipient monitoring component.

11. In addition to responding to complaints and investigations, the compliance provision of the Rule includes a recordkeeping and reporting requirement applicable to all recipients and sub-recipients which obligates CCHCS to include information concerning any compliance reviews or complaints to the Office of Civil Rights within the last five years as part of the application process. The costs of responding to any complaints and any resulting recordkeeping and reporting requirements is unknown but hard costs and staff time could be significant depending on the number of complaints submitted.

12. The Rule places at risk federal funds CCHCS receives from the U.S. Department of Health and Human Services. In the past two fiscal years, CCHCS has received over $89 million dollars from Medi-Cal, funds critically necessary to support the current level of care by civil service and contracted staff and facilities. The appointment of the federal Receiver was, in large part, due to the state's inability to adequately ensure a sufficient number of CDCR providers and arrange for an available network of community specialists and facilities. A loss of federal funding would materially undermine the efforts of CCHCS and CDCR to provide a constitutional level of health care for California inmates.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed on August 22, 2019, in Sacramento, California.

Diana Toche

Diana Toche, DDS
Undersecretary, Health Care Services
California Department of Corrections and Rehabilitation

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA, et al.,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

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

DECLARATION OF TONI TULLYS, M.P.A., DIRECTOR OF COUNTY OF SANTA CLARA BEHAVIORAL HEALTH SERVICES DEPARTMENT, IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date: October 30, 2019
Time: 8:00 AM
Courtroom: 12
Judge: Hon. William H. Alsup
Action Filed: 5/2/2019

I, TONI TULLYS, M.P.A., declare as follows

1. I am a resident of the State of California. I submit this declaration in support of the County of Santa Clara's ("County"), and its co-plaintiffs', Motion for Summary Judgment. I am over the age of 18 and have personal knowledge of all the facts stated herein. If called as a witness, I could and would testify competently to all the matters set forth below.

2. I am the Director of the County's Behavioral Health Services Department ("BHSD"), which is part of the County's broader Health System. I have held this position from December 2014 to the present. In this role, I provide leadership on behavioral health issues for all of Santa Clara County and oversee approximately 822 BHSD employees, full-time and part-time, who provide a wide array of services to safeguard and promote the health of the community. I also oversee over $500 million in behavioral health services delivered by County staff and contracted providers.

3. Prior to becoming the Director of Behavioral Health Services for the County, I was the Deputy Director of the Alameda County Behavioral Health Care Services Department. I have worked in various administrative and patient care capacities in public and private health care organizations for more than 30 years. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

4. The Behavioral Health Services Department's mission is

> "[t]o assist individuals in our community affected by mental illness and serious emotional disturbance to achieve their hopes, dreams and quality of life goals. To accomplish this, services must be delivered in the least restrictive, non-stigmatizing, most accessible environment within a coordinated system of community and self-care, respectful of a person's family and loved ones, language, culture, ethnicity, gender and sexual identity."

5. BHSD is dedicated to improving the health and well-being of Santa Clara County residents and provides an array of behavioral health services to approximately 35,000 people annually. BHSD provides preventative mental health and substance use care and also serves individuals with mental health issues, serious mental illness, and substance use disorders. These services have been developed for every age group, from newborns to the elderly. BHSD provides treatment services to a wide range of residents including Medi-Cal beneficiaries, patients with a

sliding-fee option based on their ability to pay, and a small number of commercially insured patients that receive mild to moderate services.

6. BHSD provides prevention and treatment services for all persons struggling with substance use and mental health challenges, including at-risk youth, young adults, and families. For example, it provides individual counseling, group counseling, and case management services, which may include connecting youth to medical care, legal resources, transportation, job training, psychiatric services, and housing resources. Within BHSD, a dedicated Substance Use Treatment Services division provides prevention programs to children and youth and treatment services to persons struggling with substance abuse through services such as withdrawal management, outpatient treatment, recovery services, recovery residences, Medication- Assisted Treatment (MAT), perinatal services, and residential treatment services to assist County residents who struggle with substance abuse.

7. The County provides emergency psychiatric services at Santa Clara Valley Medical Center's Emergency Psychiatric Services (EPS) facility, the only 24-hour locked psychiatric emergency room in Santa Clara County. Nearly all patients at this facility are on involuntary psychiatric holds. In addition, BHSD operates Mental Health Urgent Care a walk-in crisis clinic with a psychiatrist on duty seven days a week for those seeking voluntary services. BHSD also provides post hospital services for patients who were served by the County's 48-bed acute inpatient psychiatric unit, and BHSD contracts with three additional community hospitals for inpatient mental health treatment.

8. Federal funding, either direct or indirect, from the U.S. Department of Health and Human Services is a major component of the budget for BHSD. Funding streams to BHSD, many of which flow through the State of California, include but are not limited to Medi-Cal and Medicare payments and several sources of funding from the Substance Abuse and Mental Health Administration, among many others. In total, in a typical fiscal year such as FY 2018-19, BHSD received approximately $125.4 million in federal funds, revenue that is a significant portion of the overall budget, which had overall gross expenditures of approximately $596.6 million. Without those funds, the County Behavioral Health Services Department would have to dramatically

reduce services even while the need for mental health services is growing in Santa Clara County, and the County is planning to expand services provided through BHSD. The impact of any loss in federal funding would not be limited to services traditionally funded by federal dollars. A withdrawal of federal funding for the County would require a countywide realignment of funding and priorities, and money that is currently allocated from the County's General Fund to support programs that do not receive federal funding could be diverted to address the loss of federal funding.

9. The County Behavioral Health Services Department has a policy related to religious and moral objections to certain patient care, attached as **Exhibit A**. That policy requires BHSD staff and staff of all contracted service providers to inform BHSD prior to beginning work for BHSD, and annually thereafter, if there are certain services the provider does not offer due to religious or moral objections. BHSD will then inform beneficiaries and provide access to care through different providers.

10. BHSD's providers are expected to be competent to provide care for any patient and must not discriminate on the basis of health status or need for health care services, race, color, national origin, sex, gender, sexual orientation, gender identity, or disability. BHSD's providers also must offer culturally and linguistically competent, high-quality services to socially disadvantaged and ethnically diverse groups.

11. BHSD has a process for either patients or providers to voice concerns about their ability to continue in the treatment relationship, as building trust between the provider and patient is essential to the success of mental health treatment. When a provider is unable or unwilling to continue providing care for a patient, BHSD requires the provider to work with BHSD, which may include working directly with a new provider, to ensure continuity of care for the patient. That transition effort may also include following up with the patient to ensure they have scheduled necessary appointments and otherwise are receiving the treatments and services they need. Without timely notice of a refusal to provide care for religious or moral reasons and a smooth transition to another provider, patients may not receive necessary and timely treatment,

which could harm the patients and their communities and lead to additional healthcare needs and associated costs.

12. In my capacity as Director of Behavioral Health Services, I reviewed and am familiar with the model text for the "Notice of Rights under Federal Conscience and Anti-Discrimination Laws" from the Final Rule published by the U.S. Department of Health and Human Services, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority."

13. Many of the clinics operated by and contracting with BHSD are physically small places where notices for employees would be in plain view of patients as well. The model text may give patients the impression that providers are able to object in the moment to providing care based on their conscience, religious beliefs, or moral convictions—potentially deterring patients from sharing sensitive information that is critical to their care. For example, to receive appropriate care, patients who are seeking mental health care may need to disclose to their provider sensitive information such as their medical history or plans to seek treatments such as abortion, sterilization, assisted suicide, or gender-affirming care. But the model notice may give the client an impression that revealing such information is unwelcome or even risky.

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14. Given the vital importance in mental health care of trust between patients and providers, a notice such as this model text would unacceptably interfere with the patient-provider relationship, interrupting the continuum of care that the Behavioral Health Services Department is required to provide, interfering with the functioning of BHSD, and undermining BHSD's mission.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on September 5, 2019 in San José, California.

TONI TULLYS, M.P.A.
Director of Behavioral Health Services Department

EXHIBIT A

SANTA CLARA COUNTY
Behavioral Health Services

Policy & Procedure Number: BHSD # 2100

- [x] **BHSD County Staff**
- [x] **Contract Providers**
- [x] **Specialty Mental Health**
- [x] **Specialty Substance Use Treatment Services**

Title: LIMITATION ON MORAL OR RELIGIOUS GROUNDS

Approved/Issue Date:	**Behavioral Health Services Director:**	
Last Review/Revision Date:	**Next Review Date:**	**Inactive Date:**

REFERENCE:

- 42 CFR § 438.10 (e), (g). Information Requirements.
- 42 CFR § 438.52. Choice of MCO's, PIHPs, PAHPs, PCCMs and PCCM entities.
- 42 CFR § 438.100 (b). Enrollee Rights.
- 42 CFR § 438.102 (a)-(b). Provider-enrollee Communications.

POLICY:

Providers will not be required to deliver, reimburse for, or offer coverage of a counseling or referral service if the provider objects to the service on moral or religious grounds. Beneficiaries will know which providers have objections based on religious or moral grounds prior to referral or change.

DEFINITIONS:

Beneficiary. A Medi-Cal recipient who is currently receiving services from BHSD or a BHSD contracted provider.

Provider. A person or entity who is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide specialty mental health services and who meets the standards for participation in the Medi-Cal program as described in California Code of Regulations, title 9, Division 1, Chapters 10 or 11 and in Division 3, Subdivision 1 of Title 22, beginning with Section 50000. Provider includes but is not limited to licensed mental health professionals, clinics, hospital outpatient departments, certified day treatment facilities, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, general acute care hospitals, and acute psychiatric hospitals. The MHP is a provider when direct services are provided to beneficiaries by employees of the Mental Health Plan.

SANTA CLARA COUNTY
Behavioral Health Services

Policy & Procedure Number: BHSD # 2100

- [x] **BHSD County Staff**
- [x] **Contract Providers**
- [x] **Specialty Mental Health**
- [x] **Specialty Substance Use Treatment Services**

Title: LIMITATION ON MORAL OR RELIGIOUS GROUNDS

PROCEDURE	
Responsible Party	**Action Required**
Enrollees and Potential Enrollees	May contact the state to request information on how and where to obtains such services if BHSD chooses not to furnish the services because of moral or religious objections.
BHSD	1. Reimburses for counseling and referral services based on moral or religious grounds. 2. Notifies beneficiaries about providers that may not provide services based on moral or religious grounds at least 30 days prior to the effective date of the change. 3. Notifies enrollees at least 30 days in advance of BHSD implementing any new policy to discontinue the provision and reimbursement of counseling or referral services based on moral or religious grounds. 4. Furnishes the state with information on services it does not cover based on moral or religious grounds whenever it adopts this type of policy.
Providers	1. Prior to entering into a contract, providers will submit documentation to the BHSD about any services they do not cover because of moral or religious objections. 2. Providers will submit information to beneficiaries about any services they do not cover because of moral or religious objections. 3. Submit updates to BHSD annually or when there is a change in the services not covered due to moral or religious grounds.
Attachments:	

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
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COUNTY OF SANTA CLARA et al,
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

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

DECLARATION OF MODESTO VALLE, CHIEF EXECUTIVE OFFICER OF CENTER ON HALSTED, IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date:	October 30, 2019
Time:	8:00 AM
Dept:	12
Judge:	Hon. William H. Alsup
Trial Date:	None Set
Action Filed:	5/2/2019

I, Modesto Valle, declare:

1. Center on Halsted is a 501(c)(3) non-profit organization based in Chicago and incorporated in Illinois. Center on Halsted is a comprehensive community center dedicated to securing the health and well-being of the LGBT people of the Chicago area. More than 1,400 community members walk through our doors each day for a range of social and/or direct service engagements.

2. As a comprehensive community center dedicated to advancing community and securing the health and well-being of LGBT people in Chicago, Center on Halsted provides programs and services for the LGBT community, including case management, lunches, job development, social programing, and housing for seniors; housing, meals, counseling, and leadership development for youth; and anti-violence services. Center on Halsted provides a wide range of behavioral-health services for all ages, including gender-transition-related counseling, individual and group therapy, anti-violence crisis counseling, and HIV-related healthcare, including HIV testing and linkage to Pre-Exposure Prophylaxis or PrEP, which is extremely effective at preventing HIV transmission. Center on Halsted will soon be expanding the breadth of healthcare services that it provides via the opening of its own Health and Wellness Clinic, likely within the next year.

3. Community members not only obtain services from Center on Halsted, they also access healthcare services from a range of other community based organizations and agencies, including religiously-affiliated organizations. For example, seniors who are served by Center on Halsted currently access services through Catholic Charities and religiously-owned hospitals and care facilities, organizations that receive federal financial support for their programs and services. When these seniors encounter problems with service agencies, including denial of healthcare services based on their LGBT status or identity, Center on Halsted intervenes to advocate on the patrons' behalf. Center staff communicate with agencies informing them of their legal obligation to ensure that LGBT people who Center on Halsted serves have the ability to secure healthcare services on equal, nondiscriminatory terms. When agencies deny services to LGBT individuals, word spreads among community members, causing many of those who the Center on Halsted serves to be fearful of also being discriminated against by these organizations.

4. I have been the Chief Executive Officer of Center on Halsted since 2007 and have been instrumental in establishing many of the programs that are offered through the Center, including bringing several landmark efforts to the Center, such as the first LGBTQ-friendly affordable housing project for Seniors and the HIV/AIDS and STI Program. I attended DePaul University and Notre Dame's Seminary School. In addition, I hold certificates in nonprofit management from Harvard Business School and Northwestern University's Kellogg School of Management. I was recently appointed to the CenterLink Board of Directors and have served on the board of the NAMES Project Foundation, Equality Education Project, City of Chicago LGBT Health Council, Illinois Violence Prevention Authority Board, City of Chicago Employment Task Force, Welcoming Committee NATO, Illinois HIV/AIDS Advisory Council, Board Member of Horizons Community Services and the Chicago Children's Choir. I submit this declaration in support of Plaintiffs' Motion for Summary Judgment and in support of their opposition to Defendants' Motion to Dismiss or, in the alternative, for Summary Judgment.

5. Unless enjoined, the impact that the Denial-of-Care Rule will have on the patrons and clients whom Center on Halsted serves will be profound. People across nearly every demographic and along the entire spectrum from closeted to fully out come through Center on Halsted's doors to be in a space where they feel safe in the entirety of their authentic selves. What Center on Halsted provides is a space where judgement is not passed, nor services withheld based on personal prejudice. Center on Halsted is also a place where people do not have to sacrifice safety or delay healthcare out of fear of being told that who they are does not meet someone's moral or religious standards. If there is one thing that the 1,400 people walking through our doors have in common, it is that they know they are welcomed, whether that is to join a community group, hear a lecture, receive mental-health services, participate in a family group, take in an art show, use a computer, get an HIV test, or just relax. From our experiences serving our community, the Denial-of-Care Rule will cause the people Center on Halsted serves to feel a greater need to hide their identities and same-sex relationships when accessing healthcare services from healthcare providers outside of Center on Halsted out of fear that the healthcare providers may have religious objections to serving LGBT people. Causing clients to omit potentially vital parts of their life history may result

in a misdiagnosis and an incomplete or inappropriate treatment or recommendation. Staying in the closet may also lead to greater isolation, which is harmful in itself and negatively affects an individual's health and well-being.

6. The Denial-of-Care Rule will evoke trauma and fear among members of our community, resulting in increased demand for Center on Halsted's LGBT-affirming mental-health counseling. This will especially impact transgender and behavioral-health services that Center on Halsted currently provides. The additional demand for services and advocacy caused by discrimination resulting from the Rule will strain Center on Halsted's resources.

7. Center on Halsted will likely see an increased need for behavioral health services, especially for LGBT homeless youth who are particularly vulnerable, as many have been kicked out of their homes before encountering rejection or other discriminatory treatment by a healthcare provider. When at-risk youth experience additional rejections and denials of care by their healthcare providers, the very people whom they reach out to for support in their most vulnerable moments, they are more likely to engage in high-risk behaviors and will thus require Center on Halsted's services more often and in a greater state of trauma. With the Denial-of-Care Rule in effect, Center on Halsted may have fewer ways to mentor these youth away from high-risk behaviors when the availability of complementary support, such as replacing the familial and community safety nets with ones using social services, is reduced by discriminatory denials of service.

8. The Rule will also cause added stress on LGBT clients for whom accessing social services will be like stepping into a minefield. This will mean that Center on Halsted will need to re-examine all referral linkages, which will become increasingly difficult as the Denial-of-Care Rule will empower individuals within agencies to discriminate. In effect, this reduces the already severely damaged trust that LGBT clients – especially young clients – have, which is troubling as trust is necessary for a client to reach out for help. For example, if a young client fears that a once trusted organization may have a healthcare provider or gatekeeper whose religious beliefs about the child's gender identity reflects those of the adults who abused and abandoned them, it keeps the young person in a state of heightened vulnerability.

9. Center on Halsted is also seeing a rise in the numbers of requests for gender transition letters from our behavioral-health department. Transition letters are written by qualified Behavioral Health staff on behalf of Transgender clients seeking gender confirmation surgery. The rise in requests is likely because some transgender clients are growing more afraid of harassment, denials of care, and elongated procedures intended only to obstruct their access to transition-related care. Center on Halsted's behavioral-health staff also anticipate that already disproportionately high suicide rates within the transgender community will climb if there is a return to more obstacles to transition-related options.

10. Center on Halsted will need to educate the community about the Denial-of-Care Rule in particular in order to inform clients of the additional steps clients may need to take in order to determine whether particular providers are competent and affirming. If the law takes effect, we are likely to see an increase in reports of LGBT people being denied services. Between the Transgender Military Ban, the denial of gender self-determination for school children, and this Rule, LGBT people are negatively affected on multiple levels, which will require designing multi-level responses to address individual, interpersonal, systemic, and cultural impacts.

11. For instance, in addition to direct services, Center on Halsted provides training to healthcare professionals across fields. Due to increased stigma and discrimination, a lack of LGBT affirming healthcare options, and increased denials of care, the Denial-of-Care Rule will increase healthcare disparities affecting the LGBT community. For over a decade, Center on Halsted has invested heavily in training and providing technical assistance to the healthcare industry in Chicago related to learning to work toward ensuring equitable services to the LGBT community. The Denial-of-Care Rule will require us to re-write these training programs and any related materials as well as require us to reach out to healthcare organizations and businesses in the Chicago region to re-train their personnel. The Denial-of-Care Rule thus undermines our mission of maintaining nondiscriminatory healthcare environments at these institutions and forces us to redirect resources to retraining and ensuring that these healthcare organizations and businesses retain and reinforce their nondiscrimination requirements. Some of the training programs we have offered were funded through government grants such as the Victims of Crimes Act grant.

12. As a result of the Denial-of-Care Rule, LGBT people and people living with HIV in Illinois will be at a higher risk of lacking culturally competent healthcare providers who will not further traumatize them or exacerbate the reasons that they sought healthcare in the first place. Increased discrimination against LGBT clients creates a need for more and longer training engagements. In fiscal year 2017, Center on Halsted trainers provided twenty-five trainings to nearly 600 health and safety professionals. The Denial-of-Care Rule frustrates Center on Halsted's work in this area as it could prevent Center on Halsted from teaching and achieving its pillar principles that are based on a client-centric, nondiscriminatory approach to healthcare, including teachings that religious-based objections to treating LGBT clients, and the negative treatment of LGBT clients and clients living with HIV, can significantly and adversely alter a client's health and well-being without potentially violating the Rule. When healthcare providers affirm negative messaging about clients' self-worth, particularly during clients' most vulnerable moments of need for health-related care, clients' confidence and trust in the medical care that they receive is eroded, negatively affecting their health and well-being because they are less likely to seek care for their medical needs and by the time they do seek care, their conditions are often more acute.

13. Related to gender transitions, Center on Halsted is concerned about the Denial-of-Care Rule's preamble that characterizes transgender-affirming care as "sterilization." Much of transgender-affirming care has no impact on reproductive function or may have merely an incidental impact on reproductive function. For many transgender individuals, gender confirmation surgery is a treatment for gender dysphoria, but it is not done for the purpose of preventing procreation. Bodily autonomy is of paramount importance to everyone, including transgender individuals. While impacts on reproduction may be an incidental effect of some transgender-affirming care, such treatment is *not* sterilization.

14. Center on Halsted is working on opening its own health and wellness clinic that will include behavioral health treatment, therapy, counseling, anti-violence and youth programming, HIV-related healthcare services, PrEP services and access, additional gender-transition-related care options, and referral services to outside organizations for clients seeking healthcare options that Center on Halsted does not provide. This will be another investment Center on Halsted makes in

our community, one that is particularly important as more providers use religious-based objections to providing PrEP and other medications as a way to not serve the LGBT community.

15. The Denial-of-Care Rule will empower broad discrimination. We have heard from clients, for example, that their requests for prescriptions like PrEP were rejected because healthcare providers outside of Center on Halsted stated that providing such treatment was contrary to their moral beliefs and would, allegedly, promote "promiscuous" lifestyles and even 'gay sex' generally. Such denials of care could also lead to a rise in PTSD symptoms in those who survived the AIDS epidemic and watched friends and loved ones suffer and die when they were refused treatment within a milieu of fear which was in part perpetuated by the federal government. For clients who may have been reluctant to ask in the first place, being told that the provider morally opposes PrEP may lead the client to leave without the medication and not seek out another provider. This could impede realization of the state's Getting to Zero goal with respect to HIV transmission, which has been showing great promise, and increase the length of time and likelihood of seeing the end of the spread of HIV. This type of discrimination will increase as a result of the Denial-of-Care Rule.

16. In the weeks leading up to, and in anticipation of, the issuance of the Denial-of-Care Rule, Center on Halsted's staff devoted and since then continues to devote increased resources to strategize ways to combat negative effects from the Rule and to work with staff to develop community education options. Center on Halsted has already conducted additional "Know Your Rights" internal staff development sessions regarding discrimination against LGBT people; sent and prepared staff to attend meetings and events with other LGBT stakeholders in the city; and held internal training for staff to manage the added strains on the mental health of our clients. Center on Halsted needs to educate its community about the Denial-of-Care Rule, which erodes their confidence in the healthcare system and puts their lives and the lives of their loved ones in potential jeopardy. Center on Halsted needs to continue messaging the community about Center on Halsted's commitment to serving all clients in a non-discriminatory and welcoming manner and notify its clients that the Denial-of-Care Rule will not change Center on Halsted's commitment to providing exceptional healthcare services to all members of the community. Center on Halsted will continue fighting for its clients' rights, including, for example, advocating with other entities on behalf of

transgender clients who seek treatment for gender dysphoria, but who are denied such treatment due to providers' religious or moral objections to treating transgender clients. Center on Halsted must now devote more resources to working with outside providers and organizations to remind them of the importance of providing healthcare to all clients on non-discriminatory terms. Center on Halsted also must conduct additional internal, staff training to address and assist in managing the added strains that issuance of the Rule has already caused to Center on Halsted's staff and the people they serve. Further, Center on Halsted will ramp up its work at the intersections of identity and health, particularly focusing on transgender people of color, who already live in areas less likely to offer an array of healthcare options. The Denial-of-Care Rule thus already has required, and will further require, considerable diversion and additional expenditure of Center on Halsted's resources, and frustrates Center on Halsted's mission.

17. The Denial-of-Care Rule further adversely impacts Center on Halsted by necessitating the diversion and reallocation of resources in order to provide referrals to clients that it does not have the resources to treat either because Center on Halsted has reached its capacity for new clients (especially in the behavioral-health departments) or because the client requires treatment in a specialty that Center on Halsted does not have. These types of referrals are routine at Center on Halsted where our healthcare work focuses on behavioral health. The Denial-of-Care Rule will require Center on Halsted to expend more resources vetting healthcare providers within its referral network. Further, if a provider to whom we refer clients refuses to treat our referred clients, such a Denial-of-Care is gravely harmful to our reputation, a reputation that Center on Halsted invests heavily in with our clients, as it is essential to client trust. The Denial-of-Care Rule will make it significantly more difficult and resource-intensive for us to locate and monitor appropriate referrals. With an increase in referral requests as a result of the Denial-of-Care Rule, Center on Halsted will need to allocate additional staff time to pre-screen service referrals to ensure that staff are sending clients to LGBT-affirming providers and not to providers who themselves or whose staff would cause additional harm to Center on Halsted's clients. Moreover, Center on Halsted's staff will experience the indignity of discrimination themselves as they attempt to advocate for those whom Center on Halsted serves when healthcare providers interpret the Denial-of-Care Rule as permitting

them to deny healthcare services to LGBT clients and refuse to even refer LGBT clients to other resources. The Rule will increase Center on Halsted's operating costs and will take a toll on the health and well-being of the LGBT community that it serves.

18. Center on Halsted's job-recruitment process will be adversely affected in terms of being able to best serve the LGBT communities of Chicago. Center on Halsted would have to devote both programmatic and human-resources time to re-writing job descriptions and interview protocols to adhere to requirements under the Denial-of-Care Rule. Center on Halsted's inability under the Rule to inquire about a job applicant's willingness to treat all clients with equal dignity and respect regardless of the clients' sexual orientation or gender identity will be extremely harmful to Center on Halsted's reputation and mission. The LGBT community is not monolithic. Similarly, for instance, to how the term "Asian" encompasses many identities and cultures, LGBT is used as an expedient way to describe an otherwise incredibly diverse population. There are, for instance, lesbians who deride transgender women. It is not inconceivable that such a lesbian would seek employment at Center on Halsted and, without appropriate policies to inquire about her alignment with Center on Halsted's mission, could be hired. This would erode the very mission of Center on Halsted. To not be able to ask an applicant if they object to any part of Center on Halsted's mission would leave our communities exposed to mental and physical harms, in direct opposition to Center on Halsted's mission. Currently, for instance, Center on Halsted asks "what about the Center" attracts you as well as what experience the applicant may have working with LGBT communities. An inability to probe in connection with such questions would send a message that Center on Halsted is not interested in hiring and retaining a group of people committed to the LGBT community. Explaining this to our community would also divert already stretched resources. A similar issue of mission erosion would arise in working with volunteers.

19. One of the most disconcerting aspects of the Denial-of-Care Rule is the requirement to open confidential medical records to OCR upon its request and the fact that certain confidentiality requirements may not operate under the Rule. OCR's access to clients' medical records, especially given the recent creation of the "Conscience and Religious Freedom Division," sends a harmful signal to LGBT individuals that their medical records and well-being are vulnerable to

discrimination and misuse. This will have a chilling effect on clients' decisions regarding whether to access Center on Halsted's services. Though it is good that LGBT rights have progressed so far so quickly, this means that many LGBT people remember when information was used by the government to harm individuals in the community. The Denial-of-Care Rule will erode the trust of our communities and could lead to a return to closeted life for some. Hiding out of fear of government intrusion in one's life is a far stretch from democratic ideals.

20. The impact on the behavioral-health department will be significant. Each year, the department receives nearly 150 applications for 8 internship positions because so many students want to learn how to provide the LGBT affirming therapeutic interventions that this anchor program has developed since the founding of Center on Halsted. The department also brings on new staff and contract staff. As part of their therapeutic practice, the behavioral health team asks a therapist if they are comfortable disclosing their sexual orientation and gender identity as this is an important and crucial way to establish trust. If asking this question is no longer an option, the model will be compromised.

21. Similarly, if the HIV/AIDS & STI department hires someone who refuses to offer services by not providing HIV/HCV tests to parts of the populations served by Center on Halsted, then that person's salary is in effect wasted, while other staff members, already overworked, will be burdened with having to make up the tests if that objector decides to remain with Center's testing services. Additionally, any reception staff that works on intake for behavioral health could try to use the Denial-of-Care Rule to opt out of working with a client. Given that people making religious-based objection to assisting clients may not be required to report their actions, Center on Halsted may never know if a new client was turned away or why a long-term engaged client stopped engaging. Furthermore, even if Center on Halsted could afford to hire duplicative staff to try to protect against clients being turned away, which it cannot, there would be no way of ensuring that even the duplicative, "extra" staff would not also discriminate against clients or deny them medically necessary treatment.

22. The absence of an emergency exception is also of deep concern. If, for instance, a behavioral-health client, a homeless youth, a senior from the Center's Town Hall Residence, or any

other patron experiences an extreme situation requiring an ambulance, operations, reception, and direct-service staff are currently expected to respond immediately. Current staff understand it is their obligation to respond, but the Denial-of-Care Rule threatens that understanding. The absence of an emergency exception could mean that a client in crisis remains in a prolonged state of crisis, potentially causing greater harm to that person or persons around them. This could be as a result of emergency care services exercising religious objections to assisting clients at our Center or even Center staff refusing to abide by their mandated-reporter status that requires them under the Health Insurance Portability and Accountability Act to assist clients in need of emergency care, including calling an ambulance when necessary.

23. In addition to concerns about not being able to appropriately select and supervise staff who work directly with clients, we are also concerned about other personnel that we hire at Center on Halsted, including, for instance, custodial staff. Center on Halsted's Code of Conduct includes the requirements for anyone in the building, including staff, volunteers, interns, and patrons, to provide "considerate and respectful treatment and care" (devoid of "rude, discourteous or raucous behavior") from "experienced, professional, and responsive staff" who extend "participation in services and programs without regard to race, color, sex, gender identity, gender expression, age, religion, disability, national origin, ancestry, sexual orientation, marital status, parental status, military discharge status or source of income." The Denial-of-Care Rule invites behavior that would be contrary to Center on Halsted's Code of Conduct in that it invites discrimination against and mistreatment of LGBT clients. Center on Halsted has built its reputation on being a place where LGBT individuals can be their full, authentic selves. The Denial-of-Care Rule infringes upon our reputation and mission. The Rule could damage us to the point that the LGBT community may cease seeing Center on Halsted as a safe place for the community to go in clients' most vulnerable times of need.

24. Center on Halsted's funding may also be affected. Center on Halsted receives various forms of pass-through federal funding from HHS, including Ryan White funding and funding from the National Institutes of Health and the Centers for Disease Control and Prevention. Center on Halsted also benefits from programs governed by the Centers for Medicare through Medicare

reimbursements. If Center on Halsted chooses to best serve its communities and to follow its mission, federal dollars, which comprise about a tenth of the budget, may be cut if we are found to be out of compliance with the Denial-of-Care Rule. Center on Halsted, therefore, has a reasonable fear that it could be sanctioned and lose vital federal funding as a result of our nondiscrimination policies. The loss of such funding would result in massive service reduction and gut long standing signature programs that are the cornerstones of our work.

25. The daily administration of Center on Halsted will also be affected. When it started to become clear at the beginning of the current administration that LGBT people would experience a shift toward less support, fear and apprehension-based tensions within the community rose, particularly regarding safety concerns. At Center on Halsted, active shooter trainings have become part of all of our staff training rotations as well as part of the onboarding process for all new staff and interns. Not only are LGBT staff feeling the threat that accompanies the loss of support, they are also now on heightened alert because active shooter training is a reminder that they could very well be in harm's way if a shooter targets Center on Halsted. This, coupled with the growing number of ways that the federal government is creating laws that harm the LGBT community and dismantling the protections we worked so hard for, is creating the need for increased staff-supervision time and strategy sessions to help everyone at Center on Halsted understand, cope with, and handle the negative effects of the Denial-of-Care Rule.

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

Executed on September 6, 2019, in Chicago, Illinois.

Modesto Valle
Chief Executive Officer

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA et al,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

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

DECLARATION OF HECTOR VARGAS, EXECUTIVE DIRECTOR OF GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date:	October 30, 2019
Time:	8:00 AM
Courtroom:	12
Judge:	Hon. William H. Alsup
Action Filed:	5/2/2019

I, Hector Vargas, declare as follows:

1. American Association of Physicians for Human Rights, Inc., d/b/a GLMA: Health Professionals Advancing LGBTQ Equality, ("GLMA") is a 501(c)(3) non-profit organization based in Washington, D.C., and incorporated in California. GLMA's mission is to ensure health equity for lesbian, gay, bisexual, transgender, queer (LGBTQ) and all sexual- and gender- minority (SGM) individuals, and equality for LGBTQ/SGM health professionals in their work and learning environments. To achieve this mission, GLMA utilizes the scientific expertise of its diverse multidisciplinary membership to inform and drive advocacy, education, and research. GLMA (formerly known as the Gay & Lesbian Medical Association) was founded in 1981 and its initial mission focused on responding with policy advocacy and public-health research to the growing medical crisis that would become the HIV/AIDS epidemic. Since then, GLMA's mission has broadened to address the full range of health concerns and issues affecting LGBTQ people, including ensuring that sound science and research inform health policy and practices for the LGBTQ community.

2. GLMA represents the interests of tens of thousands of LGBTQ health professionals, as well as millions of LGBTQ patients and families around the country. GLMA's membership includes approximately 1,000 member physicians, nurses, advanced practice nurses, physician assistants, researchers and academics, behavioral health specialists, health profession students and other health professionals. GLMA's members reside and work across the United States and in several other countries. Their practices represent the major healthcare disciplines and a wide range of health specialties, including internal medicine, family practice, psychiatry, pediatrics, obstetrics/gynecology, emergency medicine, neurology and infectious diseases.

3. I am the Executive Director of GLMA: Health Professionals Advancing LGBTQ Equality. I received my bachelor of arts degree in political science and Spanish in 1989 and law degree in 1993 from the University of Georgia. I served on the Health Disparities Subcommittee of the Advisory Committee to the Director of the US Centers for Disease Control and Prevention (CDC) and served for four years on President Obama's Advisory Commission on Asian Americans and Pacific Islanders. I have more than 20 years of LGBTQ and civil rights advocacy experience,

including on staff with Lambda Legal, the National LGBTQ Task Force and the American Bar Association's Section of Civil Rights and Social Justice. I submit this declaration in support of Plaintiffs' Motion for Summary Judgment and in support of their opposition to Defendants' Motion to Dismiss or, in the alternative, for Summary Judgment.

4. The Denial-of-Care Rule fosters greater discrimination against LGBTQ patients, who already experience widespread discrimination in obtaining healthcare and suffer significant health disparities in comparison to the general population. Research documents the history of this discrimination and the negative health outcomes that result. The majority of LGBTQ patients and patients living with HIV report having experienced providers refusing to touch them or using excessive precautions, providers using harsh or abusive language, providers being physically rough or abusive, and/or providers shaming LGBTQ patients and blaming these patients for their health status. A large percentage of transgender patients report having negative experiences related to their gender identity when seeking medical care, including being exposed to verbal harassment or refusals of care.

5. LGBTQ patients face significant health disparities—higher risk factors for poor physical and mental health, higher rates of HIV, decreased access to appropriate health insurance, insufficient access to preventative medicine, and higher risk of poor treatment by healthcare providers. Denials of care by healthcare providers asserting religious objections have been detrimental to the health of LGBTQ patients. LGBTQ patients are vulnerable in other ways as well, including higher rates of poverty and limited access to LGBTQ-specific services, that present significant logistical and economic challenges to obtaining adequate healthcare. These harms are exacerbated by the Denial-of-Care Rule. The Rule will result in greater discrimination against LGBTQ patients and result in increased denials of services based not only on the medical services that patients seek, but on the patients' LGBTQ identities.

6. Among GLMA's strategic commitments is its ongoing collaboration with professional accreditation bodies, such as The Joint Commission, on the development, implementation, and enforcement of sexual-orientation and gender-identity nondiscrimination policies as well as cultural-competency standards of care for treatment of LGBTQ patients. GLMA worked with the

Joint Commission and continues to work with similar professional bodies and health professional associations on standards, guidelines, and policies that address LGBTQ health, protecting individual patient health and public health in general.

7. The Denial-of-Care Rule presents a direct conflict with nondiscrimination standards adopted by The Joint Commission and all major health professional associations, who have recognized the need to ensure LGBTQ patients are treated with respect and without bias or discrimination in hospitals, clinics, and other healthcare settings. Many of these efforts were prompted at least in part by GLMA's efforts through the years. For example, GLMA representatives, in coordination with other LGBTQ health experts, participated in the development and implementation of the hospital-accreditation nondiscrimination standards and guidelines developed by The Joint Commission to protect and ensure quality care for LGBTQ patients.

8. Similarly, GLMA has worked with the American Medical Association, among other health professional associations, over the last 15 years to ensure AMA policies prevent discrimination against LGBTQ patients and recognize the specific health needs of the LGBTQ community. All the leading health professional associations—including the AMA, American Osteopathic Association, American Academy of PAs, American Nurses Association, American Academy of Nursing, American College of Physicians, American College of Obstetricians and Gynecologists, American Psychiatric Association, American Academy of Pediatricians, American Academy of Family Physicians, American Public Health Association, American Psychological Association, National Association of Social Workers, and many more—have adopted policies articulating that healthcare providers should not discriminate in providing care for patients and clients because of their sexual orientation or gender identity. By allowing discrimination against patients on the grounds of moral and religious freedom, the proposed rule obviates the ethical and medical standards of care that healthcare professionals are charged to uphold.

9. In order for a healthcare organization to participate in and receive federal payment from Medicare or Medicaid programs, the organization must meet certain requirements, including a certification of compliance with health and safety requirements, which is achieved based on a survey conducted either by a state agency on behalf of the federal government or by a federally-

recognized national accrediting organization. Accreditation surveys include standards that healthcare organizations not discriminate based on sex, sexual orientation, or gender identity in the provision of services and in employment. A healthcare organization that discriminates on these bases in the provision of patient care or in employment, or that otherwise deviates from medical, professional and ethical standards of care is vulnerable to loss of accreditation. The Denial-of-Care Rule conflicts with these requirements.

10. If not enjoined, the Denial-of-Care Rule will cause nationwide harm to GLMA members, LGBTQ patients whose interests GLMA also represents, and the patients who GLMA members treat. The Denial-of-Care Rule creates a safe haven for discrimination and prevents GLMA from achieving its goals with professional accreditation bodies because the Rule intimidates such bodies from holding healthcare providers accountable for discrimination against LGBTQ people and denials of care when the discriminatory conduct is justified on the basis of religious or moral beliefs. The Denial-of-Care Rule would prevent agencies, to the extent allowed by law, from recognizing the loss of accreditation of a healthcare organization due to a specified anti-LGBTQ belief. The Rule, in turn, invites such facilities to discriminate against LGBTQ employees and patients without concern about the impact such discrimination will have on the organization's ability to continue receiving federal funding. The Rule, therefore, frustrates GLMA's mission of achieving and enforcing accreditation standards relating to nondiscrimination on the basis of sex, sexual orientation, and gender identity, and cultural-competency standards of care for treatment of LGBTQ patients. GLMA even works with medical organizations, like the American Academy of Dermatology, to create nondiscrimination policies and ensure their members understand and adhere to such standards. The Denial-of-Care Rule turns on its head all of the work that GLMA has accomplished in this arena.

11. Some members of GLMA are employed by religiously-affiliated healthcare organizations (for example, hospitals, hospices, or ambulatory care centers) that receive federal funds. These healthcare providers also treat LGBTQ patients. The Denial-of-Care Rule encourages religiously-affiliated healthcare employers to discriminate against employees who are GLMA members for adhering to and enforcing their medical and ethical obligations to treat all patients in

a nondiscriminatory manner, including providing all medically-necessary care that is in patients' best interests. The Rule impinges on and conflicts with GLMA members' ethical and medical standards of care that healthcare providers are charged to uphold and harms the patients that they serve.

12. The Denial-of-Care Rule invites harassment and discriminatory treatment of GLMA members in the workforce by fellow employees who claim a right to accommodation for discriminatory behavior justified by the Rule. GLMA members and their LGBTQ patients are stigmatized and demeaned by the message, communicated by the Denial-of-Care Rule, that their government privileges beliefs that result in the disapproval and disparagement of LGBTQ people in the healthcare context.

13. As an organization of health professionals who serve and care for patients from the LGBTQ community, GLMA knows that discrimination against LGBTQ individuals in healthcare access and coverage remains a pervasive problem and that often this discrimination is based in religious objections. GLMA members have reported numerous instances of discrimination in care based on religious grounds. GLMA members shared with GLMA the ways religious objections are used to the detriment of the healthcare of LGBTQ patients, including members who have said:

a. "I see patients nearly every day who have been treated poorly by providers with moral and religious objection. Patients with HIV who have been told that they somehow deserved this for not adhering to God's law. Patients who are transgender who have been told that 'we don't treat your kind here'. The psychological and physical damage is pervasive."

b. "[Some providers in my clinic] do not wish to have contact with transgender patients, mumbling religious incompatibilities when asked why. These people have made our transgender patients feel very uncomfortable and unwelcome at times, making them potentially more hesitant to use the health services they may need."

c. "The impact on my patients who were directly denied care was both psychological and physical. With regard to their mental wellbeing they

clearly felt marginalized and disrespected. With regard to their physical wellbeing, they experienced delay in care, and in some cases disruption of their routine medication dosing or diagnostic assessment."

14. Based on what patients have told GLMA members about their history and fear of discriminatory treatment, it is clear that the Rule will cause LGBTQ patients to attempt to hide their LGBTQ identities when seeking healthcare services, especially from religiously-affiliated healthcare organizations, in order to avoid such discrimination. When patients are unwilling to disclose their sexual orientation and/or gender identity to healthcare providers out of fear of discrimination and being refused treatment, their mental and physical health is critically compromised.

15. As a result of the Denial-of-Care Rule, GLMA is required to divert its resources to educate and assist its members and the LGBTQ patients its members serve to defend against the harms that the Rule causes. GLMA's staff and resources already have been diverted from other program activities to engage in advocacy, policy analysis, and program-development to address the ill-effects of the Denial-of-Care Rule. GLMA has worked tirelessly to get medical and other health associations to express their disapproval of the Denial-of-Care Rule, which has diverted large amounts of resources away from other proactive projects and outreach efforts that are core to GLMA's mission. GLMA also spends resources answering GLMA members' inquiries about the Denial-of-Care Rule given the pervasive concern that the Denial-of-Care Rule contradicts medical ethical requirements and standards of care. GLMA must spend resources educating its members and the general healthcare community about GLMA's position on the Denial-of-Care Rule and its effects on healthcare practices and providers.

16. The Denial-of-Care Rule will also adversely impact GLMA and its members by necessitating the diversion and reallocation of resources to maintain its online list of LGBTQ-affirming healthcare providers. As a result of the Denial-of-Care Rule, GLMA and its members expect to see increases in the use of this online service and must consider whether to allocate additional staff time to support this increase in website traffic. Patients have expressed concern about traveling outside of their home cities for business because if they are ever in need of

emergency medical assistance, they will not know where to go to ensure that they will receive nondiscriminatory, proper healthcare services. GLMA will need to be a resource for these patients.

17. The Denial-of-Care Rule empowers and incites religious-based discrimination against GLMA members and will contribute to discriminatory and even hostile work environments for GLMA members, LGBTQ healthcare providers, and LGBTQ-affirming healthcare providers. GLMA members who insist on treating patients equally and in accordance with medical and ethical standards of care are likely to be required to shoulder extra burdens as fellow employees decline to provide certain care. GLMA members also are likely to encounter push-back, hostility, and even adverse employment actions from their employers or fellow employees for trying to enforce nondiscrimination policies and provide appropriate care to patients. Because the vast majority of GLMA members are LGBTQ themselves, seeing LGBTQ patients treated in a discriminatory way by their colleagues and supported by their employers will have a profound impact on the environment in which they work, GLMA members will also fear that the discrimination faced by LGBTQ patients because of the Denial-of-Care Rule will also impact their own employment and ability to feel safe as LGBTQ employees. GLMA, in turn, sees and will continue seeing an increase in healthcare providers seeking its assistance with addressing such discrimination. The increased demand for such services will drain GLMA's resources and hamper other work, especially since GLMA already has a very limited bandwidth for such services.

18. As a membership organization comprising over a thousand LGBTQ health professionals, GLMA's members receive various forms of federal funding directly and indirectly via federal programs, including Public Health Service Act funding. GLMA's members may, therefore, be subject to the restrictions of the Denial-of-Care Rule. Without such funding, certain GLMA members could not provide proper treatment to their patients or proceed with their medical research programs. GLMA's members, therefore, have a reasonable fear that they could be sanctioned and lose federal funding for the work that they do as a result of nondiscrimination policies, ethical requirements, and standards of care that they enforce in their healthcare practices, which are vital to providing proper care to their patients.

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

Executed on September 5, 2019, in Washington, D.C..

Hector Vargas
Executive Director

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,

Plaintiff,

vs.

ALEX M. AZAR II, et al.,

Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,

Plaintiff,

vs.

ALEX M. AZAR, et al.,

Defendants.

COUNTY OF SANTA CLARA et al,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

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

DECLARATION OF GREG WAGNER IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date: October 30, 2019
Time: 8:00 AM
Courtroom: 12
Judge: Hon. William H. Alsup
Action Filed: 5/2/2019

I, Greg Wagner, declare as follows:

1. I have personal knowledge of the facts set forth in this declaration and, if called as a witness, could and would testify competently to the matters set forth below.

2. I am the Chief Financial Officer for the San Francisco Department of Public Health ("SFDPH"). I have served in this role since August 2011. Prior to that, I worked in the Mayor's Office of Public Policy and Finance for five years, and served as the Mayor's Budget Director from 2009-2011. Prior to joining the Mayor's Office, I spent several years on the staff of the San Francisco Planning and Urban Research Association, where I led research, policy analysis and advocacy efforts on governance and economic development issues in San Francisco. I hold a Master's degree in Public Policy from the University of California, Berkeley.

3. In Fiscal Year 17-18, SFDPH expended over $61 million in HHS grant funds that were used to fund a wide array of critical health care services and public health research. In the same fiscal year, SPDPH expended $642,304,232 in Medicaid funds and $128,336,293 in Medicare funds.

4. These funds make up approximately one-third of SFDPH's total budget, nearly 40% of Zuckerberg San Francisco General's budget, and over 60% of the budget for Laguna Honda Hospital.

5. If HHS terminated these funds, SFDPH would have to restructure the entire public health system with a drastic reduction in services. Hospital beds, behavioral health clinics, primary care clinics, and emergency services would all have to be significantly reduced. Hundreds of employees would likely lose their jobs. People in need of urgent and emergent health care may not be able to receive timely services. In short, termination of all HHS funds would cause a loss of critical health care capacity for San Francisco and the region.

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on September ___, at San Francisco, California.

9/6/19

Greg Wagner

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,

Plaintiff,

vs.

ALEX M. AZAR II, et al.,

Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,

Plaintiff,

vs.

ALEX M. AZAR, et al.,

Defendants.

COUNTY OF SANTA CLARA et al,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

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

DECLARATION OF RON WEIGELT IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date: October 30, 2019
Time: 8:00 AM
Courtroom: 12
Judge: Hon. William H. Alsup
Action Filed: 5/2/2019

I, Ron Weigelt, declare as follows:

1. I have personal knowledge of the facts set forth in this declaration and, if called as a witness, could and would testify competently to the matters set forth below.

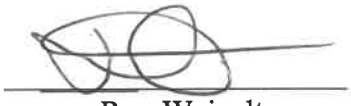
2. I am the Director of Human Resources for the San Francisco Public Health Department ("SFDPH"). I have served in this role since 2013.

3. SFDPH is the largest department in the City and County of San Francisco with approximately 8,000 staff. In addition, more than 2,000 University of California, San Francisco ("UCSF") physicians and staff work at Zuckerberg San Francisco General Hospital pursuant to an affiliation agreement between SFDPH and the Regents of the University of California.

4. San Francisco's Memorandums of Understanding with it nurses and supervising nurses—represented by Service Employees International Union ("SEIU") Local 1021—contain conscientious objection clauses, which state:

> The rights of patients to receive quality nursing care are to be respected.
>
> It is recognized that Registered Nurses hold certain moral, ethical and religious beliefs and in good conscience may be compelled to refuse involvement with abortions and other procedures involving ethical causes.
>
> Situations will arise where the immediate nature of the patient's needs will not allow for personnel substitutions. In such circumstances the patient's right to receive the necessary nursing care will take precedence over exercise of the nurse's individual beliefs and rights until other personnel can be provided.

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on September 9, at San Francisco, California.



Ron Weigelt

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,

Plaintiff,

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ALEX M. AZAR II, et al.,

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STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,

Plaintiff,

vs.

ALEX M. AZAR, et al.,

Defendants.

COUNTY OF SANTA CLARA et al,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

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

DECLARATION OF DR. BARRY ZEVIN IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date: October 30, 2019
Time: 8:00 AM
Courtroom: 12
Judge: Hon. William H. Alsup
Action Filed: 5/2/2019

I, Dr. Barry Zevin, declare as follows:

1. I have personal knowledge of the facts set forth in this declaration and, if called as a witness, could and would testify competently to the matters set forth below.

2. I am the Medical Director of Gender Health SF in the San Francisco Department of Public Health ("SFDPH"). Previously, I served as Medical Director of the Tom Waddell Health Center where I collaborated in starting Transgender Tuesdays, the first transgender primary care clinic in the country focused on homeless and other severely underserved individuals who identify as transgender. I am also an Assistant Clinical Professor of Medicine at University of California, San Francisco Medical School.

3. SFDPH provides a range of health services to transgender residents including primary and transition-related care. The transition-related services provided by SFDPH includes hormone therapy, counseling, and surgery. Several transition-related surgeries—such as mammoplasty, orchiectomy, mastectomy, and hysterectomy—are performed at Zuckerberg San Francisco General Hospital.

4. In addition, Gender Health SF provides uninsured transgender adult residents access to transgender surgeries and related education and preparation services. Gender Health SF staff help clients navigate the transition process, leading to better health outcomes.

5. The transgender community is a highly vulnerable population. Transgender individuals face unique stressors, including the stress experienced when their gender identity is not affirmed. Transgender people also experience higher rates of discrimination and harassment than their cisgender counterparts and, as a result, experience poorer health and mental health outcomes. They are also at a significantly greater risk for suicide.

6. If front-line staff, such as receptionists and call operators, refuse to direct transgender patients seeking transition-related services to the appropriate department or to schedule appointments for them, we need to be able to transfer those individuals—involuntarily if necessary—to another position. If those individuals cannot be transferred, vulnerable individuals will be deterred from accessing safe transition-related health care. In such circumstances, I have seen individuals turn to dangerous alternatives like black market hormones and industrial grade

silicone injections, which can have dire health consequences. For example, industrial grade silicone injected into the body may cause respiratory embolism, infections, scleroderma, toxic shock syndrome, granuloma, neuropathy, lymphadenopathy, rheumatic symptoms, severe autoimmune and connective tissue disorders, and even death.

7. In addition, when transgender individuals are prevented from accessing transition-related care, their risk of suicide is greatly increased.

8. In my professional experience as a doctor, the phrase "assist in the performance" is a term of art. "Assist in the performance" is generally used only in the context of a surgical or non-surgical procedure, or an exam, and refers to a doctor, nurse, medical assistant or other medical professional who physically helps the treating doctor, either by physically handling necessary instruments or by physically handling the patient. Generally, in a surgical context, only those who had "scrubbed in" to the sterile environment could be viewed as "assisting in the performance" of a surgical procedure.

9. An example of someone who could be said to "assist in the performance of a procedure" would be a medical assistant who physically ensures that a patient stays in the correct position for a doctor to perform a lumbar puncture.

10. In my experience as a doctor, in generally accepted medical parlance, the phrase "assist in the performance" would not include, for example, an individual without medical training, such as a receptionist or scheduler. Nor would it include someone who merely sterilizes instruments or prepares a room for a procedure.

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on September 9, at San Francisco, California.

Barry Zevin, M.D.

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA, et al.
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C 19-02405 WHA
No. C 19-02769 WHA
No. C 19-02916 WHA

PLAINTIFFS' SECOND REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF PLAINTIFFS' REPLY IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT

Date: October 30, 2019

Time: 8:00 AM
Courtroom: 12
Judge: Hon. William H. Alsup
Action Filed: 5/2/2019

In support of Plaintiffs' motion for summary judgment and in support of their opposition to Defendants' motion to dismiss or, in the alternative, for summary judgment, Plaintiffs respectfully request that the Court take judicial notice of the following under Federal Rules of Evidence, rule 201 and *Lee v. City of Los Angeles,* 250 F.3d 668, 688-89 (9th Cir. 2001) (stating that the court may take judicial notice of public records):

1. Food and Drug Administration's, "Importance of Influenza Vaccination for Health Care Personnel," available at https://www.fda.gov/vaccines-blood-biologics/lot-release/importance-influenza-vaccination-health-care-personnel. A true and correct copy is attached hereto as **Exhibit C**.
2. U.S. Department of Health and Human Services (HHS), Office of Population Affairs, definition of "sterilization," available at https://www.hhs.gov/opa/pregnancy-prevention/sterilization/index.html. A true and correct copy is attached hereto as **Exhibit D**.
3. HHS, "Factsheet, Final Conscience Regulation," available at https://www.hhs.gov/sites/default/files/final-conscience-rule-factsheet.pdf. A true and correct copy is attached hereto as **Exhibit E**.
4. White House, Remarks by President Trump at the National Day of Prayer Service," available at https://www.whitehouse.gov/briefings-statements/remarks-president-trump-national-day-prayer-service/, referencing issuance of final rule on May 2, 2019 (*see* https://www.hhs.gov/about/news/2019/05/02/hhs-announces-final-conscience-rule-protecting-health-care-entities-and-individuals.html). A true and correct copy is attached hereto as **Exhibit F**.
5. Excerpts from the congressional record from the 93rd Congress (Senate), Vol. 119, dated March 27, 1973. A true and correct copy is attached hereto as **Exhibit G**.
6. Excerpts from the congressional record from the 109th Congress (House of Representatives), Vol. 151, dated January 25, 2005. A true and correct copy is attached hereto as **Exhibit H**.

7. Excerpts from the congressional record from the 104th Congress (Senate), Vol. 142, dated March 19, 1996. A true and correct copy is attached hereto as **Exhibit I**.

Respectfully Submitted,

Dated: October 10, 2019

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/s/ Neli N. Palma

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Dated: October 10, 2019

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Dated: October 10, 2019

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Dated: October 10, 2019

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Dated: October 10, 2019

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** Admitted pro hac vice*

EXHIBIT C

Importance of Influenza Vaccination for Health Care Personnel

With the annual influenza season underway, the Food and Drug Administration (FDA) is urging health care organizations to ensure that influenza vaccination programs are available for health care personnel (HCP).

Because unvaccinated HCP can be a primary cause of outbreaks in health care settings, annual workplace immunization programs decrease the likelihood of contracting influenza and the chance of infecting others. Therefore, the mission to ensure patient safety in each health care setting should include influenza vaccination of personnel.

Despite the benefits of immunization, CDC estimates that only 40% of the nation's HCP are vaccinated each year. Studies have shown that low vaccination rates among HCP contribute to influenza outbreaks in hospitals and other health care settings, needlessly putting patients at an increased risk of contracting influenza and suffering from its potential major complications. Annual immunization of caregivers protects employees, their families and patients, and may reduce influenza-related deaths among persons at high risk for complications from influenza.

HCP refers to all paid and unpaid persons working in health-care settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air.

HCP might include (but are not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the health-care facility, and persons (e.g., clerical, dietary, house-keeping, laundry, security, maintenance, billing, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP and patients.

These recommendations apply to HCP in acute care hospitals, nursing homes, skilled nursing facilities, physician's offices, urgent care centers, and outpatient clinics, and to persons who provide home health care and emergency medical services.

One hospital evaluated the impact of vaccination on HCP and hospitalized patients and saw an increase in immunization coverage from 4% to 67% over 12 flu seasons. During that timeframe, laboratory-confirmed influenza cases among HCP decreased from 42% to 9%. In addition, nosocomial (hospital-acquired) influenza cases among patients decreased from 32% to 0%.

Studies have shown that some of the primary deterrents to immunization are concerns related to the safety and efficacy of the influenza vaccine. But, each year the vaccine undergoes a review by FDA to assure its safety and potency before it is approved for immunization of the public. The misconception that the vaccine causes influenza, and the mistaken belief that they are not at risk is also another reason why many HCP don't get vaccinated.

The fact is that healthy adults can pass the influenza virus to someone else one day before symptoms begin, and they can continue to infect others up to five days after getting sick. Therefore, it is possible for a healthy adult to unknowingly spread the virus to patients at high risk for serious complications from influenza.

This risk has been one of the primary factors in motivating many major professional medical societies to endorse and publish recommendations requiring HCP with direct patient care to be immunized. In fact, some states and health agencies have adopted mandatory immunization programs to help decrease the likelihood of contracting influenza and the chance of infecting others.

The initiative to improve influenza vaccination for HCP is supported by the Department of Health and Human Services (HHS), the National Foundation for Infectious Diseases (NFID), the Infectious Disease Society of America, the American College of Physicians, and the Joint Commission on Accreditation of Health Care Organizations (JCAHCO).

FDA urges health care facilities to educate their HCP regarding the benefits of influenza vaccination and potential health consequences of influenza illness for themselves and their patients. Health care systems are encouraged to implement or expand immunization programs for patients and staff. In an effort to improve vaccinations rates among HCP, HHS has developed the Health Care Personnel Initiative to Improve Influenza Vaccination Toolkit. This kit offers health care systems a comprehensive educational packet designed to help implement, or enhance existing, annual influenza vaccination programs.

Resources For You

- La Importancia de la Vacunación para el Personal Relacionado con el Cuidado de la Salud (/vaccines-blood-biologics/lot-release-biologics/la-importancia-de-la-vacunacion-para-el-personal-relacionado-con-el-cuidado-de-la-salud)

EXHIBIT G

I find no sense of obligation to the American people in an administration policy of cutting back and terminating health programs. If this policy is allowed to stand, incalculable losses will be suffered—some never to be restored—in health research, health training, and the conquest of sickness and disability.

Therefore, Congress must act, and act decisively. I urge the immediate enactment of the Public Health Service Act Extension of 1973 to enable America to get on with these absolutely essential tasks.

AMENDMENT NO. 56

Mr. CHURCH. Mr. President, I call up my amendment No. 56.

The PRESIDING OFFICER. The amendment will be stated.

The assistant legislative clerk proceeded to read the amendment.

Mr. CHURCH. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered; and, without objection, the amendment will be printed in the RECORD.

The amendment is as follows:

At the end of the bill, insert the following new sections:

SEC. 6. It is hereby declared to be the policy of the Federal Government, in the administration of all Federal programs, that religious beliefs which proscribe the performance of abortions or sterilization procedures (or limit the circumstances under which abortions or sterilizations may be performed) shall be respected.

SEC. 7. Any provision of law, regulation, contract, or other agreement to the contrary notwithstanding, on and after the enactment of the Act, there shall not be imposed, applied, or enforced, in or in connection with the administration of any program established or financed totally or in part by the Federal Government which provides or assists in paying for health care services for individuals or assists hospitals or other health care institutions, any requirement, condition, or limitation, which would result in causing or attempting to cause, or obligate, any physician, other health care personnel, or any hospital or other health care institution, to perform, assist in the performance of, or make facilities or personnel available for or to assist in the performance of, any abortion or sterilization procedure on any individual, if the performance of such abortion or sterilization procedure on such individual would be contrary to the religious beliefs of such physician or other health care personnel, or of the person or group sponsoring or administering such hospital or other institution.

Mr. CHURCH. Mr. President, recently the Supreme Court of the United States ruled in *Roe, et al.* v. *Wade, District Attorney of Dallas County* (41 U.S.L.W. 4213), that State laws which prohibit an abortion during the first 3 months of a woman's pregnancy are contrary to the due process clause of the 14th amendmend to the Constitution and, therefore, invalid. The decision, in effect, prevents any interference in the relationship between a doctor and an expectant mother during early pregnancy, with regard to her legal right to obtain an abortion.

Of course, this decision can neither be altered nor repealed by statute, since it rests upon the court's interpretation of the Constitution, the supreme law of the land. Nevertheless, the decision does raise a serious question as to its possible impact upon the Federal Government's extensive involvement in medicine and medical care.

For example, thousands of hospitals throughout the United States have been built, remodeled, enlarged, modernized or equipped under the provisions of the Hill-Burton Act. Federal money made available for this purpose, has been extended on the condition that the hospitals shall comply with certain Federal regulations. These regulations need not be prescribed prior to the acceptance of the Federal grant or loan, but may be stipulated afterward.

Thus the requirement that hospitals, furnished Hill-Burton funds, must prove that charity patients account for not less than 3 percent of their yearly operating costs, represents a relatively recent condition laid upon most hospitals after they had obtained the Federal money. Once having accepted the money, the hospitals are subject thereafter to comply with such regulations as the Federal administrative agency may choose to impose.

Physicians who participate in the medicare and medicaid programs could find themselves in the same predicament. Their eligibility might come to be conditioned upon their willingness to perform all those services prescribed by Federal regulations.

Given this state of the law, I can well understand the deep concern being expressed by hospital administrators, clergymen, and physicians whose religious beliefs prohibit abortions and/or sterilization in most cases. Catholic hospitals, for example, do not permit their facilities to be used for the performance of an abortion under ordinary circumstances. It is simply contrary to the Catholic faith, regardless of what the civil law may say.

Nothing is more fundamental to our national birthright than freedom of religion. Religious belief must remain above the reach of secular authority. It is the duty of Congress to fashion the law in such a manner that no Federal funding of hospitals, medical research, or medical care may be conditioned upon the violation of religious precepts.

Now is the time to erect the appropriate safeguards against such transgressions. Even though the Supreme Court's decision does not impose the obligation upon a hospital, there is nothing in existing law to prevent zealous administrators from requiring the performance of abortions, within the limits of the Court's decision, as a part of their regulations pertaining to federally funded programs.

This apprehension is anything but whimsy. Already a case has arisen which should furnish us with ample grounds for legislative action. A Federal district court in Montana, in the case of Mike and Gloria Taylor against St. Vincent Hospital, has issued a temporary injunction, compelling a Catholic hospital, contrary to Catholic beliefs, to allow its facilities to be used for a sterilization operation. The district court based its jurisdiction upon the fact that the hospital had received Hill-Burton funds.

Given the injunction issued by the court against St. Vincent's Hospital in Billings, together with the possible administrative ramifications of the recent Supreme Court decision on abortions, it should be evident that a provision needs to be written into the law to fortify freedom of religion as it relates to the implementation of any and all Federal programs affecting medicine and medical care.

For this purpose, I have called up the amendment that is now pending, and I hope that the manager of the bill will accept it. The amendment would simply clarify the intent of Congress with respect to the significance of accepting Federal funding as it might apply to the question of performing abortions or sterilizations in religious affiliated hospitals where such operations are contrary to religious belief.

Mr. President, if Congress fails to clarify its intention, then we face a plethora of lawsuits. The effect will be so debilitating in many communities that Congress ought to take timely action to avoid it.

Already in my own State, where the people have been made aware of the Montana decision to which I have referred, there has been a striking outcry. The Catholic bishop in Spokane has spoken of civil disobedience. There is open conjecture in the press that obstetrics divisions of Catholic hospitals might be closed to perform operations contrary to their religious beliefs.

Nothing in the decision of the Supreme Court requires Congress to lay down such a rule, but the present law is not explicit on this point. Either we are going to have a uniform rule laid down by Congress, which has the power to impose such conditions as it may choose upon the acceptance of Federal money, or we are going to leave this to many different courts to decide, without the benefit of any explicit expression of congressional intent. That will cause chaos. Now it is time to speak. Now when we are faced with the extension of these programs. That is the purpose of the amendment and I hope it is possible for the manager of the bill to accept it.

Mr. STEVENSON. Mr. President, will the Senator yield?

Mr. CHURCH. I am happy to yield to the distinguished Senator from Illinois.

Mr. STEVENSON. Mr. President, first of all I commend the Senator from Idaho for bringing this matter to the attention of the Senate. I ask the Senator a question.

One need not be of the Catholic faith or any other religious faith to feel deeply about the worth of human life. The protections afforded by this amendment run only to those whose religious beliefs would be offended by the necessity of performing or participating in the performance of certain medical procedures; others, for moral reasons, not necessarily for any religious belief, can feel equally as strong about human life. They too can revere human life.

As mortals, we cannot with confidence say, when life begins. But whether it is life, or the potentiality of life, our moral convictions as well as our religious beliefs, warrant protection from this in-

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trusion by the Government. Would, therefore, the Senator include moral convictions?

Would the Senator consider an amendment on page 2, line 18 which would add to religious beliefs, the words "or moral"?

Mr. CHURCH. I would suggest to the Senator that perhaps his objective could be more clearly stated if the words "or moral conviction" were added after "religious belief." I think that the Supreme Court in considering the protection we give religious beliefs has given comparable treatment to deeply held moral convictions.

I would not be averse to amending the language of the amendment in such a manner. It is consistent with the general purpose. I see no reason why a deeply held moral conviction ought not be given the same treatment as a religious belief.

Mr. STEVENSON. The Senator's suggestion is well taken. I thank him.

Mr. CHURCH. Mr. President, I ask unanimous consent that my amendment may be modified by adding, on line 18, page 2, after the words "religious belief", the three words—"or moral conviction".

The PRESIDING OFFICER. The Senator has a right to so modify his amendment. The amendment will be so modified.

Mr. CHURCH. I thank the Senator from Illinois very much for the suggestion he has made. I think it improves the amendment.

Mr. STEVENSON. Mr. President, the U.S. Supreme Court in its abortion decision has found for women a new right of privacy in the 14th amendment and virtually no rights under that amendment for the unborn. I would have thought that such moral questions as when life begins and may be terminated in the womb would best be left to the elected representatives of the people in their legislatures.

Being mortals, we cannot with confidence say when life begins. I believe the Government in all its branches should move with the greatest reluctance to diminish the value of human life on all questions—whether it be the termination of life, or its potentiality in the womb, or the imposition of capital punishment.

I sense a growing acceptance of human life as but another commodity in a world which knows too much of violence and too little of the human spirit. Human life is in danger of becoming but a fragment of an increasingly anonymous, depersonalized collective existence. The Government ought, it seems to me, in its actions sanctify human life, never cheapen it. And when governmental decisions are taken which defy the competence of mortals and risk a diminution of human life, such as the legalization of abortion, they should be taken by elected bodies representing a public consensus.

The Court has effectively prevented States from prohibiting abortion during the first 6 months of pregnancy. That might be a proper decision for a State legislature, though I personally would be most reluctant to permit abortion on demand after the first quickening in the womb, that is, after the first trimester. The Court has not said that the Federal Government must affirmatively require or encourage abortion or sterilization in federally supported medical facilities. To go that far would give individuals an intolerable choice of either rejecting Federal assistance necessary to the welfare of the sick—or of aiding in the performance of acts they deem immoral. The Constitution poses no such dilemma for American citizens. It does not dictate our moral beliefs. And I do not believe Congress ever intended to do so. Yet, a Federal court has already required a hospital to allow its facilities to be used for the performance of sterilization. It based its decision upon the fact that the hospital received Hill-Burton funds from the Federal Government.

One need not be of one religious faith or another to be offended by such a governmental intrusion into the religious beliefs of citizens. This could be but the first blow in a more general assault upon the religious and moral beliefs of individuals whose only offense is a reverence for human life and a professional commitment to serve it. A further concern is the possibility that medical facilities may be forced to reject Federal support or to close obstetrical operations. It is difficult for me to see the gains in such a policy no matter how one looks at it. Doctors would not be denied the chance to perform these medical procedures by the Church amendment. They can be performed often in doctors' offices and often in other facilities. No individuals will be denied an abortion or sterilization consistent with their own religious or moral convictions, if at the same time the moral and religious convictions of others are respected by the amendment. Some medical facilities will be closed to the performance of such medical procedures, but the religious and moral beliefs of those who serve in such facilities will be protected from intrusion by the Government.

I must side with the protection of deep-felt religious and moral convictions, even if it causes some inconvenience to doctors and patients. I therefore commend the Senator from Idaho for offering his amendment and accepting the modification I proposed. That modification merely extends the protection of the amendment to those who for moral, as opposed to religious, reasons cannot in good conscience participate in medical procedures which terminate life, or its potentiality. The amendment, as modified, makes it clear that no law of the Congress requires a doctor, or hospital, or other health care personnel, to perform or allow to be performed in its facilities, an abortion or sterilization procedure.

Mr. GRIFFIN. Mr. President, I wish to indicate that I support this amendment. However, it will be necessary to have a rollcall vote on it. I suggest the absence of a quorum.

Mr. CHURCH. Mr. President, will the Senator withhold his request for a quorum call

Mr. GRIFFIN. I withhold my request.

Mr. CHURCH. Mr. President, I ask unanimous consent that the distinguished senior Senator from Delaware (Mr. ROTH) be added as a cosponsor of the amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRIFFIN. Mr. President, I renew my request.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GRIFFIN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. NUNN). Without objection, it is so ordered.

Mr. GRIFFIN. Mr. President, I ask for the yeas and nays on the pending Church amendment.

The yeas and nays were ordered.

QUORUM CALL

Mr. KENNEDY. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The second assistant legislative clerk proceeded to call the roll.

Mr. ROBERT C. BYRD. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

UNANIMOUS-CONSENT AGREEMENT

Mr. ROBERT C. BYRD. Mr. President, I am authorized by the distinguished manager of the bill (Mr. KENNEDY), the distinguished assistant Republican leader (Mr. GRIFFIN), the distinguished Senator from New York (Mr. JAVITS), the distinguished Senator from Idaho (Mr. CHURCH), and the distinguished Senator from Florida (Mr. GURNEY) to propose the following unanimous-consent request:

I ask unanimous consent that time on the bill presently before the Senate be limited to 1 hour, to be equally divided between the distinguished Senator from Massachusetts (Mr. KENNEDY) and the distinguished Senator from New York (Mr. JAVITS); that time on the pending amendment by the distinguished Senator from Idaho (Mr. CHURCH) be limited to 1 hour, to be equally divided between the distinguished author of the amendment (Mr. CHURCH) and the distinguished Senator from New York (Mr. JAVITS); that time on the amendment by the distinguished Senator from Florida (Mr. GURNEY) be limited to 1 hour, to be equally divided between the distinguished author of the amendment (Mr. GURNEY) and the distinguished manager of the bill (Mr. KENNEDY); that time on any other amendment, debatable motion, or appeal be limited to 30 minutes, to be equally divided and controlled in the usual form; that Senators in control of the time on the bill may yield therefrom to any Senator on any amendment, debatable motion or appeal; that no amendments not germane be in order with the exception of the aforementioned amendments in the event they may not be considered germane; and that the time begin running on the bill or the Church amendment at 2 p.m. today.

Mr. JAVITS. Mr. President, will the Senator from West Virginia yield?

Mr. LONG. Mr. President, I object. I object.

The PRESIDING OFFICER (Mr. NUNN). Objection is heard.

Mr. ROBERT C. BYRD. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. ROBERT C. BYRD. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ROBERT C. BYRD. Mr. President, was it not the understanding of the Chair on the agreement which I proposed just a moment ago, if accepted, that the time thereon would begin running only at 2 p.m. today?

The PRESIDING OFFICER. That was the statement made, yes.

Mr. ROBERT C. BYRD. I thank the Chair and I renew my request.

The PRESIDING OFFICER. Is there objection to the unanimous-consent request of the Senator from West Virginia?

Mr. JAVITS. May I ask the Senator if he would now propose that we recess until 2 o'clock?

Mr. ROBERT C. BYRD. I think there will be some legislative history to be made first, after which the distinguished manager of the bill, at his discretion, will recess the Senate until 2 p.m. today.

The PRESIDING OFFICER. Is there objection to the unanimous-consent request of the Senator from West Virginia? The Chair hears none, and it is so ordered.

Mr. LONG. Mr. President, I should like to ask the distinguished Senator from Idaho (Mr. CHURCH) if he would respond to one or two questions that I have. What was intended by the words on page 2, line 19 "* * * of such physician or other health care personnel * * *"?

The thought occurs to me that it would seem reasonable to say that where one seeks a sterilization procedure or an abortion, it could not be performed because there might be a nurse or an attendant somewhere in the hospital who objected to it. If it was not a matter of concern to that individual, it seems to me that that is getting to be a little far-fetched, that is, that someone who had nothing to do with the matter and was not involved in it one way or the other, just someone who happened to be working in a hospital, and was not involved in an abortion or a sterilization procedure, could veto the rights of a physician and the rights of patients to have a procedure which the Supreme Court has upheld.

Mr. CHURCH. Let me make clear, Mr. President, that such is not my intention. I understand the basis for the expression of concern on the part of the Senator from Louisiana, but the words on line 19, "* * * of such physician or other health care personnel, * * *" relate back to the same words used on lines 12 and 13 and must be read in context with those words.

Mr. LONG. If I understand what the Senator is saying, he is saying that a nurse or an attendant who has religious feelings contrary to sterilization or abortion should not be required and would not be required by any Federal activity to participate in any such procedure to which they hold strong moral or religious convictions to the contrary.

Mr. CHURCH. That is correct.

Mr. LONG. So that this would not, in effect, say that one who sought such an operation would be denied it because someone working in the hospital objected who had no responsibility, directly or indirectly, with regard to the performance of that procedure. It would only be that one who was involved in performing the operation or in assisting to perform the operation could not be required to participate when he or she held convictions against that type of procedure.

Mr. CHURCH. The Senator is correct. The amendment is meant to give protection to the physicians, to the nurses, to the hospitals themselves, if they are religious affiliated institutions. So the fact Federal funds may have been extended will not be used as an excuse for requiring physicians, nurses, or institutions to perform abortions or sterilizations that are contrary to their religious precepts. That is the objective of the amendment. There is no intention here to permit a frivolous objection from someone unconnected with the procedure to be the basis for a refusal to perform what would otherwise be a legal operation.

Mr. LONG. I thank the Senator for that explanation.

Mr. KENNEDY. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. KENNEDY. Mr. President, I ask unanimous consent that the order for the quorum call be rescended.

The PRESIDING OFFICER. Without objection, it is so ordered.

RECESS UNTIL 2 P.M.

Mr. KENNEDY. Mr. President, I move that the Senate stand in recess until 2 p.m. today.

The motion was agreed to; and (at 1:12 p.m.) the Senate took a recess until 2 p.m.; whereupon, the Senate reassembled when called to order by the Presiding Officer (Mr. DOMENICI).

MESSAGE FROM THE PRESIDENT

A message in writing from the President of the United States was communicated to the Senate by Mr. Marks, one of his secretaries.

The message is as follows:

To the Senate of the United States:

I am returning today without my approval S. 7, the "Rehabilitation Act of 1972."

This bill is one of several now before the Congress which mask bad legislation beneath alluring labels.

Their supporters would have the American public believe that each of these bills would further an important social cause, but they neglect to warn the public that the cumulative effect of a Congressional spending spree would be a massive assault upon the pocketbooks of millions of men and women in this country. They also fail to warn us that simply throwing money at problems does not solve anything; it only creates poor legislation which frequently misses the target.

As President, it is my duty to sound the warning—and to defend the public interest by vetoing fiscally irresponsible, badly constructed bills that come to my desk from Capitol Hill. S. 7 is such a bill.

Over the past nineteen months, we have made significant headway toward a goal that has eluded America for nearly two decades: full prosperity without war.

But all of our economic progress—and all of our hopes—will be washed away if we open the floodgates on the Federal budget.

S. 7, if enacted, would result in an increase in Federal outlays of some $1 billion above my budget recommendations for fiscal years 1973–1975.

To some Members of the Congress, a $1 billion increase in Federal spending may seem only a small crack in the dam. But there are more than a dozen other bills already before the Congress which also carry extravagant price tags. And more seem likely to follow during the remainder of the year.

If we allow the big spenders to sweep aside budgetary restraints, we can expect an increase of more than $50 billion in Federal spending before the end of fiscal year 1975. This would force upon us the unacceptable choice of either raising taxes substantially—perhaps as much as 15% in personal income taxes—or inviting a hefty boost in consumer prices and interest rates.

The American people have repeatedly shown that they want to hold a firm line on both prices and taxes. I stand solidly with them. At a time when the world is watching to see if we can demonstrate our willingness to hold down inflation at home while we seek monetary stability abroad, this resolve is more important than ever. I shall therefore veto those big-spending bills which would jeopardize our economic hopes for the future.

I would emphasize that even if S. 7 were not fatally flawed by its large expense, I would have serious reservations about signing it, for it also contains a number of substantive defects. Among them:

—It would divert the Vocational Rehabilitation program from its original purposes by requiring that it provide new medical services. For instance, it would set up a new program for end-stage kidney disease—a worthy concern in itself, but one that can be approached more effectively within the Medicare program, as existing legislation already provides.

Vocational Rehabilitation has worked well for over half a century by focusing on a single objective: training people for meaningful jobs. We should not dilute the resources of that program or distort its objective by turning it toward welfare or medical goals.

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—Secondly, S. 7 would create a hodgepodge of seven new categorical grant programs, many of which would overlap and duplicate existing services. Coordination of services would become considerably more difficult and would place the Federal Government back on the path to wasteful, overlapping program disasters.

—By rigidly cementing into law the organizational structures of the Rehabilitation Services Administration and by confusing the lines of management responsibility, S. 7 would also prevent the Secretary of Health, Education, and Welfare from carrying forward his efforts to manage vocational rehabilitation services more effectively.

—Finally, by promising increased Federal spending for this program in such a large amount, S. 7 would cruelly raise the hopes of the handicapped in a way that we could never responsibly hope to fulfill.

Through past increases in funding and by our efforts to find more effective means of providing services, this Administration has demonstrated its strong commitment to vocational rehabilitation. Funding for the Vocational Rehabilitation program will reach $650 million under my budget for the coming fiscal year, an increase of 75 percent over the level of support when I took office. Two other sources of funding for rehabilitation of the handicapped, the Disability Insurance Trust Fund and the new Supplemental Security Income program, will provide another $100 million. Altogether during the coming fiscal year, the Vocational Rehabilitation program should provide services for about 1.2 million people—an increase of more than 50 percent over the figure of four years ago.

This is a good record and one that provides promise for the future. I shall thus look forward to working with the Congress in developing a more responsible bill that would extend and strengthen the Vocational Rehabilitation program.

This Administration has submitted recommendations to both the 92nd and 93rd Congresses which would accomplish these purposes. The 92nd Congress passed a bill which contained some of my recommendations but was so inordinately expensive that I felt compelled to veto it. In returning S. 7 without my approval, I ask the 93rd Congress now to turn its attention to the substitute recently offered by Representative Earl Landgrebe.

My decision to disapprove S. 7 should be seen by the Congress as more than just an isolated rejection of a single piece of unwise legislation. It is part of my overall commitment to hold down taxes and prices. I remind the Congress of that determination, I ask the Congress to consider carefully the implications of spend-thrift actions, and I urge the Congress to be more reasonable and responsible in the legislation it passes in the future.

RICHARD NIXON.

THE WHITE HOUSE, *March 27, 1973.*

PRESIDENT'S VETO MESSAGE ON REHABILITATION ACT OF 1972 (S. DOC. NO. 93-10)

Mr. ROBERT C. BYRD. Mr. President, I ask unanimous consent that the President's veto message with respect to S. 7, the Rehabilitation Act of 1972, be printed as a Senate Document.

The PRESIDING OFFICER (Mr. DOMENICI). Without objection, it is so ordered.

ORDER TO HOLD MESSAGE AT THE DESK

Mr. ROBERT C. BYRD. Mr. President, I ask unanimous consent that the President's veto message be temporarily held at the desk.

The PRESIDING OFFICER. Without objection, it is so ordered.

PUBLIC HEALTH SERVICE ACT EXTENSION OF 1973

The Senate continued with the consideration of the bill (S. 1136) to extend the expiring authorities in the Public Health Service Act and the Community Mental Health Centers Act.

The PRESIDING OFFICER. The question before the Senate is on agreeing to the amendment by the Senator from Idaho (Mr. CHURCH) to S. 1136. Under the unanimous consent agreement, the 1 hour allotted for debate on the amendment will be divided between the Senator from New York (Mr. JAVITS) and the Senator from Idaho (Mr. CHURCH).

Who yields time?

Mr. JAVITS. Mr. President, I yield myself 2 minutes.

The PRESIDING OFFICER. The Senator from New York is recognized for 2 minutes.

Mr. JAVITS. Mr. President, a parliamentary inquiry.

The PRESIDING OFFICER. The Senator from New York will state it.

Mr. JAVITS. Are amendments to the Church amendment which are germane to the amendment in order?

The PRESIDING OFFICER. They are in order when the time has expired on the amendment.

Mr. JAVITS. I thank the Chair.

Now, Mr. President, in view of the fact that Senators may not know that the Senate is now in session, I hope, with the concurrence of the other side, that I may ask unanimous consent for a brief quorum call with the time to be charged equally to both sides.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. JAVITS. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The second assistant legislative clerk proceeded to call the roll.

Mr. JAVITS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. DOMENICI). Without objection, it is so ordered.

Mr. JAVITS. Mr. President, I hope the attachés of the Senate will notify the Senator from Idaho (Mr. CHURCH) that his amendment is now under consideration.

The reason why I have urged the Senate to take a little time to consider this amendment is that it is a matter of very great social and political importance in the country, both within the States and within the Nation, as to what we shall do about abortion.

It will be noted that the Church amendment, as proposed to public health programs does two big things. First, it declares it a policy of the Federal Government, in the administration of all Federal programs—I emphasize that—that religious beliefs which proscribe the performance of an abortion shall be respected. Then it proceeds to implement that provision with simply the negative of the proposition: That is, where they are prohibited by religious beliefs rather than where religious beliefs may encourage their utilization.

Further, the amendment inhibits the exercise of this right granted, according to the Supreme Court, by the Constitution of the United States to an individual woman, where the institution—which is the thing that is troubling me here the institutional view—or the individual physician, or other health personnel has a religious objection to performing or assisting or making facilities available in respect to any abortion or sterilization procedure.

If this were confined to the moral and religious convictions of the individual—that is, the physician or the individual health personnel. I do not see how anybody can object. But I am very deeply disturbed about the fact that we may be adopting a completely unconstitutional amendment in this bill with respect to abortion, when one reads the case of Roe against Wade. This is the landmark case, which settled this issue, the opinion being delivered by the Supreme Court on January 22, 1973, Opinion No. 70-18 of the U.S. Supreme Court. There were both concurring and dissenting opinions in that matter, but the majority was very deeply convinced and apparently prevailed, and that is the law of the land.

So question No. 1, which is very important, is whether or not there is equal protection of the laws with respect to an institution, again leaving aside the individual but that I can understand, and there I think the Constitution operates affirmatively; that is, the individual has a right to follow his religious views when it guides his individual action.

The second half of it, however, is where it is an institution; and the question is whether that institution can have a religious view because of the religious view, as this proposed amendment says, of the person or group sponsoring or administering such hospital or other institution.

Can an institution or a group have a religious scruple without violating the establishment clause of the Constitution?

The other thing that troubles me about the all-inclusive character of this amend-

ment is that this relates to giving Federal help to such an institution. Question: Is it equal protection of the laws to give help to such an institution which proscribes or prohibits abortion or sterilization procedures, which is now a perfectly lawful hospital function, while such aid is given to other institutions which furnish such service? Question: Is that giving a particular benefit which is discriminatory and not equal protection of the laws?

The question which the Supreme Court faced did not arise in this way, because in the case of Roe against Wade, the issue was whether State laws which prohibited abortion except for medical reasons, in emergency cases, were constitutional. That, of course, involved the 14th amendment, and there the court held that they were not constitutional; and this opinion is very illuminating in addressing ourselves to this subject.

I refer to page 37 of the opinion, which gives the rationale. I read from that page as follows:

> The court has recognized that a right of personal privacy or a guarantee of certain areas or zones of privacy does exist under the Constitution.

Then it goes on to say, on the next page:

> The court's decisions recognizing the right of privacy also acknowledge that some state regulation in areas protected by that right is appropriate.

So that is not an unqualified right.

Then the court lays it off with two juridical concepts, at the bottom of page 37 of the opinion, by the following:

> This right of privacy—whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon State action, as we feel it is, or, as the District Court determined, in the Ninth Amendment's reservation of rights to the public, is broad enough to encompass a woman's decision whether or not to terminate her pregnancy.

The Court held in the affirmative, that it was; and the Court—that is, the Supreme Court—based its decision upon the 14th amendment, the very same amendment which not only assures personal liberty but also assures equal protection of the laws.

This is the question we face, Mr. President: Suppose we have an area in which practically no services of this kind are available yet we have the amendment which Senator CHURCH has proposed. Quite apart from the equal protection of the laws as to individual hospitals and other institutions—whether that is discriminatory—but going only to the question of the woman's right, and that is the right of privacy the court was seeking to protect, if she cannot get that service practically, is she not being denied a right under the 14th amendment, especially where it is attributable to the Federal Government's action in giving support to that particular institution, notwithstanding the fact that it denies her the right of privacy which the Supreme Court has sustained?

Mr. President, the reasons why I raise these questions, which are profound questions, are these: If we should enact law which contains this amendment pretty much as we have it here, raising these issues will advise the Supreme Court of the United States that the question of constitutionality was raised; that the points which seemed at least one lawyer to be inherent in adopting this amendment were brought up; and that the Senate thereupon—because we will have a record vote—made its decision in the light of the questions raised regarding constitutionality. That is point one.

The other point which I think is very important is that the Supreme Court will hear—I am sure that other lawyers in the Chamber will wish to join issue—other views concerning constitutionality as it affects our vote; and therefore the Court will be enlightened and informed by actions which are, as we lawyers say, part of the res gestae—that is, happened at the time of the heat of the struggle—and be aided in making its decision. It must be realized, Mr. President, by those who vote, whichever way they vote, that this is a justiciable question and undoubtedly will be submitted for consideration by the courts. So much for the constitutional issue.

I would like to move now to the practicalities of the amendment itself, and if I may have Senator CHURCH's attention, I would appreciate it greatly. It has been suggested to me that two amendments are necessary if we would go this route.

One would be a provision that such a hospital or health care institution as is benefited by this amendment may, notwithstanding the fact that State laws may not proscribe such treatment, proscribe it itself because of the religious views of those who sponsor or administer it. Should we not provide that no such institution, however, may discriminate against a doctor or against health personnel who do not entertain those religious or philosophical beliefs, rather than to allow that view on the part of the institution itself to affect the individual liberty of the individuals who may not agree?

Question: Should there be a proper nondiscrimination clause in this amendment?

Second, should not the fact that the hospital or other institution entertains this policy be very open and public; so that, for example, a woman is not going to dash into such a hospital without notice that the hospital will not do what she may want done, and therefore she would be able to help herself by seeking assistance elsewhere?

So I would like to address those points to the Senator from Idaho. I have drafted amendments on that score, which may be desirable, assuming that the Senate may well adopt this amendment, to make these two provisions respecting its form.

Finally, I would be less than fair to my friend and colleague, for whom I have great respect, if I did not say that to me, without in any way anticipating how I shall vote on the matter, it would cause me much less pain on constitutional grounds if the institutional reference were eliminated. I could see it respecting philosophy or the religion of any other person engaged in giving care, and I would not want to punish a hospital or other institution because it employed or had on its staff such personnel. But I am deeply concerned on constitutional grounds when we make it institutional and provide that hospitals or other institutions may prescribe this form of treatment, with respect to the religious views or philosophical views—because we have added the words "or moral conviction," which broadened it considerably—"of the person or group sponsoring or administering such hospital or other institution."

It is not easy. I know people have shied away from this debate in all States of the Union, but nonetheless, the fact is that we have passed an effective law in the State of New York, and the Supreme Court, in what I consider to be one of its most historic and constructive adjudications, has laid down the rules regarding this matter in its own decision. I felt it necessary to speak rather than just let this amendment go by, which would have been easy to do because there seems to be a feeling that when you get into hot subjects like this that it is better to let them go by and not discuss them. I do not feel that way. The Supreme Court has spoken, and the Supreme Court has made a fair disposition of the case, with the greatest respect for the religious views of a large body of Americans. I would hope that settled the question. I believe it does. I certainly go with the Supreme Court's decision.

But here is yet another aspect of it which has been raised by the amendment of the Senator from Idaho (Mr. CHURCH) which is not covered directly on point by the decision. I felt it my duty as a Senator and as a lawyer, coming from a State that has legalized abortion, to raise these constitutional issues for the information of my colleagues and the ultimate utilization by the court of last resort.

I reserve the remainder of my time.

Mr. CHURCH. Mr. President, I yield myself such time on the amendment as I may require.

The PRESIDING OFFICER. The Senator is recognized.

Mr. CHURCH. Mr. President, I have listened to the distinguished Senator from New York with the interest and consideration that any remarks he makes on this floor deserve. He is a constitutional lawyer and he has addressed himself to the constitutional aspects of this question.

I also have examined the decisions of the Supreme Court, the Rowe against Wade decision, and another decision, that of Doe against Bolton. I think we should be clear as to what the Court decided in the case of Rowe against Wade. It decided that State governments may not outlaw abortion during the first 3 months of pregnancy. It did not decide that religious affiliated hospitals had an affirmative duty to perform abortions, if contrary to the religious precepts of those institutions. It did not decide that the right of privacy to which the Senator from New York referred is a right re-

served only to the individual. On the contrary, the Court said in Rowe against Wade, making reference to the second case that I will speak to in a moment——

Mr. JAVITS. Where is the Senator reading?

Mr. CHURCH. I am reading from the decision of Rowe against Wade, page 49 of the court decision. The court said:

> In Doe v. Bolton procedural requirements contained in one of the modern abortion statutes are considered. That opinion and this one, of course, are to be read together.

Let us turn from the Rowe against Wade decision, where the court decided that no State law which prohibits abortion in the first 3 months of a woman's pregnancy is valid under the 14th amendment to the Constitution, to the case of Doe against Bolton. Doe against Bolton had to do with a Georgia statute relating to State control over abortion. That case addressed itself to the issue of whether hospitals themselves had rights apart from rights that may be enjoyed by individuals or rights of religious belief.

At page 16 of the decision the court said:

> . . . it is to be remembered that the hospital is an entity and that it, too, has legal rights and legal obligations.

But the court went on, citing section 26–1202(e) of the Georgia statutes:

> Under § 26–1202(e) the hospital is free not to admit a patient for an abortion. It is even free not to have an abortion committee. Further, a physician or any other employee has the right to refrain, for moral or religious reasons, from participating in the abortion procedure. These provisions obviously are in the statute in order to afford appropriate protection to the individual and to the denominational hospital. Section 26–1202(e) affords adequate protection to the hospital and little more is provided by the committee prescribed by § 26–1202(b)(5).

Although this is dicta, it is clear the Supreme Court itself suggested in these two decisions that it is laying no affirmative duty upon denominational hospitals to perform abortions and that hospitals, as well as individuals, have legal rights which the Court itself respects.

I think that raising the constitutional question here is not supported by the two relevant Supreme Court decisions. We are faced with an entirely different question which is not constitutional in character.

No, Mr. President, this amendment is addressed to an entirely different issue. It is addressed to the intent of Congress. As matters now stand, the Federal law simply does not make it clear what requirement Congress intends to impose upon religiously affiliated hospitals if they receive Federal money. The state of the law needs to be clarified.

I do not bring this amendment to the floor today for any whimsical reason. I am not conjuring up apparitions. Already we have had court decisions that raise this question and make it apparent that Congress must act promptly to resolve the question before this becomes an issue for disruption, dissent and hysteria in the land.

I cited a case previously in Montana where a court held that because a hospital had received Hill-Burton funds, the Federal court had jurisdiction to issue an injunction requiring the hospital to make its facilities available for a sterilization operation, which was contrary to the religious precepts of the church-supported hospital.

I have already cited the reaction to that decision. The Bishop in Spokane said he is prepared to practice civil disobedience before he permits Catholic hospitals to perform operations contrary to their religious beliefs.

I have already cited the real and present danger that many of these religious hospitals, if coerced into performing operations for abortions or sterilizations contrary to their religious precepts, will simply eliminate their obstetrics department.

Do we want this to happen? I do not think that the Congress intends that Federal money should be used as a lever to force religious hospitals or Catholic doctors to perform operations that are contrary to their moral convictions or religious beliefs. It was the last thing Congress had in mind when Hill-Burton funds were made available—that there was some hidden condition that would later attach to the acceptance of these funds that would force Catholic hospitals to perform abortions or sterilizations.

Can anyone say it would be fair that because a hospital had received Federal money 15 years ago—when no one had any thought that the abortion issue would become the issue it is today—to build a wing, to add a new surgical operating room or, to obtain certain modern equipment, that the Federal Government could come along 15 years later and say, "Owing to the fact that you accepted Federal funds for these purposes, you are now required to perform abortions?" Do you think it is fair to the hospital or to the people affiliated with it to impose such after-the-fact requirements upon them? Of course Congress did not intend it so, but not until today has it been necessary for Congress to explicitly state that it imposes no such requirement when it extends Federal moneys to assist these hospitals in the performance of their functions?

Mr. President, it is widely recognized that such a clear statement of congressional intent has become necessary. The Catholic Conference of Bishops has expressed its support for this amendment. They recognize the necessity to clarify the law. But this is not simply a Catholic question. There are many other religions that have strong feelings concerning abortions and sterilizations that are equally affected. In my own State, for example, there are hospitals affiliated with the Mormon Church, the Church of Jesus Christ of Latter-Day Saints. The position of that church on the question of abortion is similar to the position of the Catholic church. And throughout the land we have other church-affiliated hospitals that are equally concerned.

I think, for the benefit of giving us some perspective on this question, it would be appropriate to mention here that 19 percent of the Nation's hospitals are affiliated with one or another church. Of this 19 percent, 29 percent of the church-affiliated hospitals are protestant, 64 percent are Catholic, 2 percent are Jewish, and 5 percent are of other religious denominations.

So this amendment addresses itself to a distinct minority of our hospitals. One thousand one hundred and eighty-six is the total figure. Most of our hospitals are not church owned, and this amendment would not in any way affect sterilizations or abortions in publicly owned hospitals.

This amendment does not lay down any requirement on any hospital as to what it may or may not do. This amendment is directed at what the Federal Government may or may not do. It clears up an ambiguity in the present law by making it explicitly clear that it is not the intention of Congress to mandate religious hospitals to perform operations that are contrary to deeply held religious beliefs.

Now, we have to make a choice, and it would be difficult for me to believe that the Congress of the United States could make any other choice but to uphold freedom of religion, which is one of the most basic and sacred of those liberties for which this land stands.

Even if we were to make a different choice, even if we were here to decide, or at some later date to decide, that we would make it a condition for the acceptance of Federal funds to lay upon the religious hospitals an affirmative duty, that they perform abortions and sterilizations or other procedures that were contrary to their religious precepts, then surely we would want to do it in such a way that it would have a prospective effect. Surely we would not want to do it in such a form that hospitals would be required to perform such services because they had accepted Federal funds 10 and 15 years ago. That is preposterous.

No matter how you look at this question, the time has come for Congress to make clear what it intends.

The time is upon us because we have a bill pending that would extend Hill-Burton and other federally financed medical programs. So, we cannot dodge the issue. We have to face up to it now and set down a uniform standard for the courts and for those Federal administrators charged with the responsibility of carrying forward these Federal programs.

Mr. President, I have modified my amendment in one regard, at the request of the distinguished Senator from Illinois (Mr. STEVENSON), to include in addition to the religious beliefs, moral convictions, because the Supreme Court has given moral convictions a status comparable to religious beliefs in this field.

I see no reason why the amendment ought not also to cover doctors and nurses who have strong moral convictions against these particular operations. That is the only modification to the amendment. And I think it has improved the amendment.

I would hope that as we approach a vote the Senate would make it clear by an overwhelming vote that we do not intend that Federal money should be conditioned upon the violation of deeply held religious beliefs or moral convictions.

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Mr. NELSON. Mr. President, will the Senator yield for a question?

Mr. CHURCH. I yield.

Mr. NELSON. Mr. President, does the amendment go on line 19?

Mr. CHURCH. The Senator is correct. The moral convictions go after "religious beliefs."

Mr. NELSON. Mr. President, due to my own dereliction, I did not get around to reading the amendment until just now. I did not realize that it was to be called up. However, I wish the Senator from Idaho would clarify something for me.

Is the Senator saying in section 7 only that a doctor or health personnel of some kind may as individuals refuse on their own to participate in any surgery involving sterilization or abortion? Is that what the Senator is saying?

Mr. CHURCH. That is one of the things I am saying.

Mr. NELSON. That is all right. I do not quarrel with that. However, I am wondering whether there is any way to compel them anyway. Has anyone suggested compelling a doctor to perform an abortion if it is against his religious belief or moral conviction?

Mr. CHURCH. I would say to the Senator that we are already faced with a situation in which a hospital that is church affiliated, a Catholic hospital in Montana, has been enjoined to permit the performance of a sterilization operation contrary to the Catholic belief. In that case the Federal Court based its jurisdiction upon the grounds that that hospital had heretofore accepted Federal money for construction under the Hill-Burton Act.

Obviously this could be the beginning of a whole plethora of court decisions based upon Federal funding and placing upon those who receive Federal funds a requirement that as a condition for eligibility they must perform certain operations that may be contrary to their moral conviction or religious belief.

I think that Congress should make it clear that we do not intend that Federal money be conditioned in this way.

Mr. NELSON. Mr. President, did the Senator place in the RECORD the rationale of the Federal judgment, that the judge based his injunctive relief upon the proposition that the Supreme Court decision therefore made it obligatory upon the hospital to perform this surgical procedure?

Mr. CHURCH. In this particular case, the judge based his jurisdiction on the fact that the hospital had previously received Hill-Burton funds, not in any way upon the recent decision of the Supreme Court relating to abortion procedures. This amendment makes it clear that Congress does not intend to compel the courts to construe the law as coercing religious affiliated hospitals, doctors, or nurses to perform surgical procedures against which they may have religious or moral objection.

Mr. NELSON. Is it the intent of section 7 that the refusal to permit the performance of the surgery involving sterilization or abortion in the hospital must be based upon a moral conviction or religious belief?

Mr. CHURCH. The Senator is correct.

Mr. NELSON. Mr. President, does that mean then that if a hospital board, or whatever the ruling agency for the hospital was, a governing agency or otherwise, just capriciously—and not upon the religious or moral questions at all—simply said, "We are not going to bother with this kind of procedure in this hospital," would the pending amendment permit that?

Mr. CHURCH. The amendment would not touch this operation based upon religious freedom and the prerogatives of church-affiliated hospitals.

Mr. NELSON. Mr. President, I thank the Senator.

Mr. CHURCH. Mr. President, I see that my time is rapidly expiring. In the time remaining I would like to briefly relate the situation in my own State.

Idaho has 47 generally approved hospitals, two of which are LDS and eight of which are Catholic affiliated.

The LDS affiliated hospitals are located in St. Anthony, Idaho Falls, and Cassia County, Idaho.

The Catholic affiliated hospitals are located in Idaho Falls, Pocatello, Arco, Jerome, Boise, Nampa, Cottonwood, and Lewiston.

These church-affiliated hospitals serve approximately 40 to 50 percent of the population. A majority of the hospitals are publicly owned. There is no great difficulty for those who wish to obtain a sterilization or an abortion operation to go to the publicly owned hospitals where such procedures are available.

The Senator from New York said that we should amend this so as to impose some of public notice. However, it has been commonly understood throughout our life that Catholic hospitals do not perform abortions except under extraordinary circumstances where life may require it. We do not have to put a pubic notice on the front door of a Catholic hospital to tell the people what they already know.

This amendment does not impose any requirements on the hospital. It merely says that the Government does not impose a new requirement conditioning the acceptance of Federal money upon the performing of certain operations that are contrary to religious beliefs, or deeply held moral conviction.

Let it be clear that Congress does not intend to impose such a requirement upon the acceptance of Federal funds.

I would like to make it clear in connection with my own State that Mr. John Hutchison, of the Idaho Hospital Association, has told me that no area of Idaho would be without a hospital within a reasonable commuting distance which would perform abortion or sterilization procedures. Moreover, in an emergency situation—life or death type—no hospital, religious or not, would deny such services.

There is no problem here. The people understand the situation.

The PRESIDING OFFICER. All time of the Senator from Idaho has expired.

Mr. CHURCH. So for this reason, I hope that the Senate will see fit to adopt the amendment.

Mr. KENNEDY. Mr. President, a parliamentary inquiry.

The PRESIDING OFFICER. The Senator will state it.

Mr. KENNEDY. How much time remains?

The PRESIDING OFFICER. The Senator from New York (Mr. JAVITS) has 10 minutes.

Mr. KENNEDY. I yield the junior Senator from New York (Mr. BUCKLEY) 3 minutes on the bill.

Mr. BUCKLEY. Mr. President, I compliment the Senator from Idaho for proposing this most important and timely amendment. It is timely in the first instance because the attempt has already been made to compel the performance of abortion and sterilization operations on the part of those who are fundamentally opposed to such procedures. And it is timely also because the recent Supreme Court decisions will likely unleash a series of court actions across the United States to try to impose the personal preferences of the majority of the Supreme Court on the totality of the Nation.

I believe it is ironic that we should have this debate at all. Who would have predicted a year or two ago that we would have to guard against even the possibility that someone might be free to participate in an abortion or sterilization against his will? Such an idea is repugnant to our political tradition. This is a Nation which has always been concerned with the right of conscience. It is the right of conscience which is protected in our draft laws. It is the right of conscience which the Supreme Court has quite properly expanded not only to embrace those young men who, because of the tenets of a particular faith, believe they cannot kill another man, but also those who because of their own deepest moral convictions are so persuaded.

I am delighted that the Senator from Idaho has amended his language to include the words "moral conviction," because, of course, we know that this is not a matter of concern to any one religious body to the exclusion of all others, or even to men who believe in a God to the exclusion of all others. It has been a traditional concept in our society from the earliest times that the right of conscience, like the paramount right to life from which it is derived, is sacred.

The PRESIDING OFFICER. The Senator's 3 minutes have expired.

Mr. KENNEDY. I yield the Senator 3 more minutes on the bill.

Mr. BUCKLEY. In this amendment, we seek to protect the right not only of institutions, but of individual doctors and individual nurses throughout this country, to live by their own consciences. Through the adoption of this amendment, we will try to insure that individuals and institutions will not be penalized because of the recent Supreme Court decisions.

I urge my colleagues to adopt the amendment overwhelmingly.

Mr. KENNEDY. Mr. President, I yield myself 5 minutes on the bill.

During the course of the consideration of this legislation, we have heard the

senior Senator from New York enumerate some very interesting and challenging constitutional questions which are raised by this amendment. Let me say, as chairman of the Health Subcommittee, that we did not have an opportunity to examine the amendment in our committee in the hearings or in the markup. During the course of the hearings, we heard only from the Secretary of HEW, and solely on the question of the extension of the existing Federal health legislation that expires in June. Thus we did not have the opportunity to consider this amendment on its merits or in light of the various constitutional question it raises. It is understandable why the Senator from Idaho would raise this issue here. I think it is equally understandable why the senior Senator from New York and others are concerned about the constitutional implications of the question, particularly since we have not had a chance to give it the attention we might have liked.

Mr. President, there are really two potentially conflicting provisions of the first amendment relating to the constitutional issue here. There is the establishment clause of the first amendment, and there is the free exercise clause of the first amendment. I would agree with the interpretation presented by the senior Senator from New York (Mr. JAVITS), namely, that Congress has the authority under the Constitution to exempt individuals from any requirement that they perform medical procedures that are objectionable to their religious convictions. Indeed, in many cases, the Constitution itself is sufficient to grant an exemption to protect persons from official acts that infringe on their free exercise of religion. I think of the Selective Service cases in the Supreme Court, granting exemptions from the draft in circumstances broader than those granted by Congress. I think of *Sherbert* v. *Verner*, 374 U.S.C. 398 (1963), the landmark decision by the Warren court, protecting Seventh-day Adventists from State requirements that they be willing to work on Saturdays as a condition of qualification for unemployment compensation. I think of *Wisconsin* v. *Yoder*, 406 U.S.C. 205 (1972), the most recent authoritative ruling of the Supreme Court, in which the Court, in a unanimous decision on this issue by Chief Justice Burger, held that Amish children were not required to attend the public schools of Wisconsin. In both of these decisions, the Court, emphasizing its strong concern to protect the free exercise of religion of the individuals involved, held that the exemptions were not an unconstitutional establishment of religion.

The more difficult question is whether Congress can exempt the institution itself. The first amendment to the Constitution, which includes both the establishment clause and the free exercise clause, also includes clauses protecting freedom of speech and freedom of the press.

We know that in the recent Pentagon papers case, for example, the freedom-of-speech protection was applied not only to the individuals as members of the press, but also to institutions of the press, such as the New York Times and the Washington Post. Thus, there are strong precedents in the first amendment area for organizations and institutions to avail themselves of its protections in their own right.

In addition, however, whatever the ability of a hospital or other institution to invoke the free exercise of religion clause in its own right to sustain the exemption in the pending amendment. There is strong authority for the view that Congress has broad leeway to define what is necessary and proper for the protection of first amendment rights of individuals. Since the days of John Marshall and the decision in McCulloch against Maryland in the early 19th century, the Supreme Court has given Congress wide power in exercising its best judgment to protect individual rights and liberties. I believe that the Court will sustain the judgment of Congress that, in order to give full protection to the religious freedom of physicians and others, it is necessary to extend the exemption in the pending amendment to the facilities where they practice their profession and livelihood.

I think the case that has been made by the Senator from Idaho (Mr. CHURCH) in justification of this provision fully warrants favorable consideration by this body. Therefore, I intend to support the amendment.

I would indicate to the Senator from Idaho that while we will have to take this matter to conference, the discussion of constitutional issues and questions which have been raised this afternoon will continue. I would certainly hope that he will counsel with us and assist us as we prepare for the conference, so that we will be able to resolve these questions in as satisfactory manner and achieve the goal of his amendment.

I hope that Senators will support the amendment.

The PRESIDING OFFICER. Who yields time?

Mr. JAVITS. Mr. President, I yield myself 4 minutes.

The Senator from Masachusetts (Mr. KENNEDY) has expressed very well for himself and myself the purport of the amendment. However, I think we ought also to define our terms.

One or two of the points made by the Senator from Idaho (Mr. CHURCH) do need to be made clear for the RECORD. He spoke constantly of our mandating hospitals to engage in these operations. Obviously, we are not mandating hospitals to do anything. We are only deciding who shall get Federal help and who shall not, and they shall all offer the same range of services. Or shall one group of hospitals be excluded from that particular service which is in the range of the others' services.

But, as he said, we cannot undercut a decision on a constitutional matter, in fairness to the Court and ourselves, except to raise it, which I have done, and I think it is our duty to do it. The Court will decide that point, but will know, at least, that we have recognized the issue.

Furthermore, publicly owned hospitals are not independently owned hospitals; indeed, they are the minority of hospitals. In most cases, hospitals are privately owned. There are 4,838 nongovernmental hospitals and 2,159 governmental hospitals, which includes Federal, State, and local Government hospitals. I hope that we will be able to deal with that in conference. That gave me trouble, the words—

> or of the person or group sponsoring or administering such hospital or other institution.

That is a very loose phrase. I do not know when a person sponsors or administers. Suppose the superintendent of a hospital was Catholic, but the hospital was not a Catholic hospital, and he had concerns, but the hospital did not; does that mean that if the superintendent asserted his beliefs, that would be the end of the matter for the hospital he is administering, but by no means dominating its policy? As happens in all amendments on the floor, we have to take into consideration the looseness of the language which may be employed and do our utmost with it in conference. Once the issue, such as the issue here, has been resolved, it will be by the way in which the Senate acts.

Finally, Mr. President, I should like to point out that there is nothing about this that corrects any errors of the past. What we are doing is having legislation which relates to the future, in the words—

> there shall not be imposed, applied, or enforced—

Which obviously, again, I think in conference, if necessary, we could make clear. If this becomes a policy of law, we will not have one policy for the future and apply another one with forfeiture in the past.

There is only one real basic point that I hope the Senator from Idaho might reconsider his position on, and that is on the question of notice. That is important. I do not see why the institution would not be proud to post a notice, giving everyone notice that they cannot seek that kind of help in that particular hospital. Then they could, indeed, do what he said occurs in his own State of Idaho—which is a perfectly proper argument—go elsewhere, because, in my view, the courts may very well come down on the practical end of this, and that is, decide it on exactly that basis, that the Federal Government has a right to finance activities, even with this particular provision in it, as long as the service is obtainable, so that the individual is not cut off from the opportunity to obtain it somewhere within practicable range of the particular place the individual is located.

So, I would hope that when the time expires, the Senator from Idaho might consider, one, the nondiscrimination amendment, that is, against personnel in such an institution who might have other views and, two, the notice amendment which would simply construct a total policy for Congress and then, assuming that is passed, it would be our duty to give the utmost attention we could to the Senator's intent and try to lock it into the bill. That will make it effective and that will give us the best chance to have it stand up constitutionally.

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I might say to the distinguished Senator from Idaho——

Mr. CHURCH. Mr. President, if I may interject there, is the Senator prepared to offer two amendments on this?

Mr. JAVITS. Yes. I have both of them and I will send them to the Senator right away.

I should like to say to the Senator that if he desires any more time for his discussion, we can yield it to him on the bill; but I would like to say this, that he has made a splendid argument, as the Senator from Massachusetts (Mr. KENNEDY) said, and I think his argument, his and mine, and that of Senators KENNEDY and BUCKLEY, will be extremely useful both in fashioning the legislation and in any adjudication—and we will undoubtedly have adjudication—by the courts.

The PRESIDING OFFICER (Mr. DOMENICI). The Senator's 4 minutes have expired.

Who yields time?

Mr. KENNEDY. Mr. President, I suggest the absence of a quorum and ask unanimous consent that the time not be charged against either side.

The PRESIDING OFFICER. Without objection, it is so ordered, and the clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. JAVITS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. JAVITS. Mr. President, I yield back the remainder of my time.

The PRESIDING OFFICER. The question is on agreeing to the amendment.

Mr. JAVITS. Mr. President, I send amendments to the desk.

The PRESIDING OFFICER. The amendments will be stated.

The legislative clerk proceeded to read the amendments.

Mr. JAVITS. Mr. President, I ask unanimous consent that further reading of the amendments be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered; and, without objection, the amendments will be printed in the RECORD.

The amendments are as follows:

On page 1, line 3, strike the words "religious beliefs which proscribe" and insert in lieu thereof "religious beliefs or moral convictions regarding".

On page 2, add after line 21 the following new sections:

"SEC. 8. In respect of a hospital or other health care institution referred to in Section 7 such hospital or other health care institution shall not discriminate in the employment, promotion, extension of staff or other privileges or termination of employment of any physicians or other health care personnel on the basis of their personal religious or moral convictions regarding abortion or sterilization or their participation in such procedures.

"SEC. 9. Any individual, hospital or other health care institution declining to participate in such procedures on the grounds of such religious or moral convictions shall post notice of such policy in a public place in such institution."

Mr. JAVITS. Mr. President, I ask unanimous consent that the amendments may be considered en bloc.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. JAVITS. Mr. President, I have submitted this amendment not with any thought of doing anything other than what the Senate wishes to do in respect to this matter, but I do believe that it is appropriate to give the measure a proper balance as we pass it. I intend, if my amendments are adopted, to vote with Senator CHURCH.

The first amendment relates to the catechism on page 1, line 3, and substitutes as a declaration of policy the words "religious beliefs and moral conviction" instead of "religious beliefs which proscribe."

Mr. President, I ask that the amendment be revised accordingly—"religious beliefs and moral conviction regarding".

The PRESIDING OFFICER. The Senator has a right to so modify his amendment.

Mr. JAVITS. So that it reads, in lieu of the words "religious beliefs which proscribe" because that only relates to one kind of attitude—in order to give it balance, "religious beliefs and moral convictions regarding."

Mr. CHURCH. Mr. President, will the Senator yield?

Mr. JAVITS. I yield

Mr. CHURCH. I suggest "religious beliefs or moral conviction."

Mr. JAVITS. Fine. It will read "religious beliefs or moral conviction regarding." I modify my amendment to read that way.

On page 2, section 8 would be an addition. Nothing is changed in Senator CHURCH's amendment, except that this addition is included:

In respect of a hospital or other health care institution referred to in section 7—

That is, Senator CHURCH's amendment—

such hospital or other health care institution shall not discriminate in the employment, promotion, extension of staff or other privileges or termination of employment of any physician or other health care personnel on the basis of their personal religious or moral convictions regarding abortion or sterilization or their participation in such procedures.

I wish to make it clear that that particular amendment simply will protect anybody who works for that hospital against being fired or losing his hospital privileges if he does not agree with the policy of the hospital and goes elsewhere and does what he wishes to do, but he cannot do it in that hospital, and Senator CHURCH is right about that. There, the hospital controls.

Mr. CHURCH. In other words, if a physician who was part of a staff of a Catholic hospital, let us say, who was not himself a Catholic and had no compunction about performing sterilization or abortion operations, were to perform them in some other hospital, a public hospital, where there is no feeling against it, then he would not be discriminated against by the Catholic hospital for having performed those operations elsewhere.

Mr. JAVITS. Exactly.

Mr. CHURCH. I am in full accord with that, and I think that helps to improve the amendment.

Mr. JAVITS. Section 9 would add the notice aspect we discussed, and it does not have to be some blatant, ridiculous nailing of x points on the door of the hospital. We do not expect that. It is just so that the people are informed of the policy of that hospital.

Mr. JACKSON. Mr. President, will the Senator yield, so that I might ask a question of the Senator from Idaho to clarify a matter contained in his amendment?

Mr. JAVITS. May I just finish this?

Mr. JACKSON. All right.

Mr. JAVITS. This is section 9:

Any individual, hospital or other health care institution declining to participate in such procedures on the grounds of such religious or moral convictions shall post notice of such policy in a public place in such institution.

I yield to the Senator.

Mr. JACKSON. I should like to ask the distinguished Senator from Idaho a question with respect to clarifying the intent of the amendment on the specific point as to whether or not his amendment in effect preempts State law.

I refer specifically to section 2, which was contained in the original Senate Joint Resolution 64, and which is now being offered in the form of an amendment. Section 2 starts out "Any provision of law."

As I understand the position of the Senator from Idaho, that refers to Federal law, and his amendment does not preempt State law in this particular field.

Mr. CHURCH. The Senator is correct. Nothing in this amendment undertakes to preempt or interfere with State law.

Mr. JACKSON. I thank the distinguished Senator from Idaho for clarifying that point. There was a question in my mind, based on the language in the amendment. I believe the Senator has now made it very clear. He is the author of the amendment, and I do not think there is any doubt about the meaning of the amendment.

Mr. JAVITS. That is a very good point.

Mr. CHURCH. I think the point is well taken.

Mr. President, although I have said to the able Senator from New York that I see no particular need to post notices in Catholic hospitals that abortions are not normally performed there, I have no particular quarrel with a notice provision if the Senator feels that one should be added to this amendment. It is possible that in some cases such a notice provision would help to advise the individuals in the public as to where they should go if they are looking for a sterilization or an abortion operation. Therefore, I have no objection to this amendment in either of its aspects, and I hope the Senate will adopt it.

Mr. BUCKLEY. Mr. President, will the Senator yield?

Mr. JAVITS. I yield.

Mr. BUCKLEY. I should like to get some clarification.

The effect of the proposed amendment of the Senator from New York would be to eliminate the words "which proscribe" and substitute the word "regarding." Is that correct?

Mr. JAVITS. That is correct.

Mr. BUCKLEY. I am not sure whether

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this is a distinction with a difference or not.

Mr. JAVITS. There is no secret about my purpose. It only seeks to balance out a statement of policy. We are going to respect whatever the religious or moral convictions are on either side of the case, and our purpose is to respect them. That is the reason for the nondiscrimination portion.

Mr. BUCKLEY. Therefore, if a particular institution did in fact proscribe these medical procedures, the Federal Government would be without power to override that policy?

Mr. JAVITS. That is correct.

Mr. BUCKLEY. I thank the Senator.

Mr. JAVITS. Mr. President, I am ready to yield back the remainder of my time.

Mr. CHURCH. I yield back the remainder of my time.

The PRESIDING OFFICER. Does the Senator from Massachusetts yield back his time on the amendment to the amendment?

Mr. KENNEDY. May I withhold the time?

The PRESIDING OFFICER. Who yields time?

Mr. JAVITS. I withhold my time.

Mr. PASTORE. Mr. President, will the Senator yield? I would like 3 minutes to ask a question.

Mr. KENNEDY. I yield.

Mr. JAVITS. Mr. President, is it on the amendment to the amendment?

Mr. KENNEDY. Yes.

Mr. PASTORE. As a matter of fact, it is on the whole thing. The amendment of the Senator is going to be accepted, so it is part of the package. I hope I am not being limited.

My question is this: What the Senator from Idaho is actually doing in his amendment is to say that Hill-Burton funds shall not be denied to any hospital that does not choose to allow abortions to be committed within that hospital.

Mr. CHURCH. If the refusal is based upon religious beliefs or moral convictions against such procedure.

Mr. PASTORE. Naturally, that is what the case would be.

The amendment of the Senator from New York goes on to say that in the event any doctor who does practice in this hospital does commit an abortion in another hospital that does permit abortions to be committed, he shall not be barred from practicing in the first hospital.

Where do we get that right to tell a hospital what to do or what not to do? Is that hospital not a private organization?

Mr. CHURCH. The Senator is correct but the Senator's amendment—and the Senator from New York can speak for it best—provides that any hospital accepting Federal funds will do so with the understanding.

Mr. PASTORE. In other words, what the Senator is actually saying is that if the first hospital bars that physician who committed an abortion in the other hospital, it shall be denied Hill-Burton funds.

Mr. CHURCH. No.

Mr. JACKSON. There is no penalty.

Mr. KENNEDY. Mr. President, will the Senator yield?

Mr. CHURCH. I yield.

Mr. KENNEDY. As I understand it, these hospitals are already receiving Federal funds. Therefore the requirement is that they shall not discriminate.

Mr. PASTORE. But if they do, what happens?

Mr. JACKSON. Nothing.

Mr. PASTORE. Then, what are we doing? We have wasted a whole morning doing nothing.

Mr. JACKSON. Mr. President, will the Senator yield?

Mr. PASTORE. I yield to anyone who can clear it up.

Mr. JACKSON. I cannot clear it up, but I cannot see in the combination any penalty, unless I do not read it correctly.

Mr. PASTORE. My question is in two parts. First, how does the Congress of the United States impose on the discretion, judgment, and right of doctors of the private hospital, whether Catholic, Jewish, or Protestant; and, two, if it does and can do it, what is the penalty?

Mr. JAVITS. Mr. President, if the Senator will yield, I am the author of the amendment so perhaps I should answer. In the first place, it is not imposing a duty on any hospital except the hospital seeking to qualify for Federal funds. Then it says that notwithstanding that, the hospital may participate in the program. That is the affirmative benefit. But it qualifies the benefit by saying that if they do discriminate against the doctor who is in their hospital because he has done something they do not approve of in the other hospital, we have the authority to deprive them of that benefit.

Mr. PASTORE. What is the benefit?

Mr. JAVITS. The Federal money given for example under Hill-Burton.

Mr. PASTORE. Then there is the penalty. It sounds dictatorial.

Mr. JAVITS. These are Federal benefits under a Federal program which some may get and some may not get, depending on many forms of qualification. One form may be the range of hospital services. The Senator from Idaho provides, and I agree, that the particular hospital does have to give the same range of medical benefits as any other hospital. I say, very well, they still get the money if they do not. But suppose that hospital fires a doctor because they do not approve of what he did in another hospital. I say they do not have the right to fire him, and they may lose the benefits of Federal funds because they are discriminating against a doctor. So you have two conditions.

Mr. PASTORE. So there is a penalty.

Mr. JAVITS. I hope so. I do not know if it will be so adjudicated by the administrator, but it is there.

Mr. PASTORE. Let us assume it is a private hospital, be it Catholic or Jewish, and, as a rule, that any person who is on the staff of that hospital and commits an abortion in another hospital, when the first hospital does not permit an abortion to be committed, and that hospital does not receive one red cent from the Federal Government, then what is the penalty?

Mr. JAVITS. None whatever, and the law does not apply.

Mr. PASTORE. Can that physician be discharged from that hospital under the Senator's amendment?

Mr. JAVITS. Yes.

Mr. PASTORE. For having committed an abortion in another hospital?

Mr. JAVITS. Yes.

Mr. PASTORE. It all comes down to Federal funds.

Mr. JAVITS. Nothing else

Mr. CHURCH. The Senator is correct.

The PRESIDING OFFICER. Do Senators yield back their time?

Mr. JAVITS. I yield back my time.

Mr. CHURCH. I yield back my time.

The PRESIDING OFFICER. The question is on agreeing to the amendment of the Senator from New York to the amendment of the Senator from Idaho (putting the question).

The amendment was agreed to.

The PRESIDING OFFICER. The question now is on the amendment of the Senator from Idaho as amended. The yeas and nays have been ordered and the clerk will call the roll.

The legislative clerk called the roll.

Mr. ROBERT C. BYRD. I announce that the Senator from Louisiana (Mr. JOHNSTON), the Senator from New Jersey (Mr. WILLIAMS), the Senator from California (Mr. TUNNEY), and the Senator from Maine (Mr. MUSKIE) are necessarily absent.

I also announce that the Senator from Mississippi (Mr. STENNIS) is absent because of illness.

I further announce that, if present and voting, the Senator from California (Mr. TUNNEY), the Senator from New Jersey (Mr. WILLIAMS), and the Senator from Louisiana (Mr. JOHNSTON) would each vote "yea."

Mr. GRIFFIN. I announce that the Senator from Massachusetts (Mr. BROOKE) is absent by leave of the Senate on official business.

The Senator from Wyoming (Mr. HANSEN) is necessarily absent.

The result was announced—yeas 92, nays 1, as follows:

[No. 64 Leg.]

YEAS—92

Abourezk	Eastland	McIntyre
Aiken	Ervin	Metcalf
Allen	Fannin	Mondale
Baker	Fong	Montoya
Bartlett	Goldwater	Moss
Bayh	Gravel	Nelson
Beall	Griffin	Nunn
Bellmon	Gurney	Packwood
Bennett	Hart	Pastore
Bentsen	Hartke	Pearson
Bible	Haskell	Pell
Biden	Hatfield	Percy
Brock	Hathaway	Proxmire
Buckley	Helms	Randolph
Burdick	Hollings	Ribicoff
Byrd, Harry F., Jr.	Hruska	Roth
Byrd, Robert C.	Huddleston	Saxbe
Cannon	Hughes	Schweiker
Case	Humphrey	Scott, Pa.
Chiles	Inouye	Scott, Va.
Church	Jackson	Sparkman
Clark	Javits	Stafford
Cook	Kennedy	Stevens
Cotton	Long	Stevenson
Cranston	Magnuson	Symington
Curtis	Mansfield	Taft
Dole	Mathias	Talmadge
Domenici	McClellan	Thurmond
Dominick	McClure	Tower
Eagleton	McGee	Weicker
	McGovern	Young

NAYS—1

Fulbright

NOT VOTING—7

Brooke	Muskie	Williams
Hansen	Stennis	
Johnston	Tunney	

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So Mr. CHURCH's amendment, as amended, was agreed to.

Mr. GURNEY. Mr. President, I call up my amendment.

The PRESIDING OFFICER. The amendment will be stated.

The legislative clerk proceeded to state the amendment.

Mr. GURNEY. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 9, lines 8 and 9, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $31,500,000 for the period ending October 31, 1973".

On page 9, line 12 and 13, strike out the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $8,330,000 for the period ending October 31, 1973".

On page 9, lines 16 and 17, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $6,000,000 for the period ending October 31, 1973".

On page 9, lines 20 and 21, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $5,330,000 for the period ending October 31, 1973".

On page 9, lines 24 and 25, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973 and $5,000,000 for the period ending October 31, 1973."

On page 10, lines 3 and 4, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $10,000,000 for the period ending October 31, 1973."

On page 10, line 7, strike "June 30, 1974" and insert in lieu thereof "October 31, 1974."

On page 10, lines 9 and 10, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $6,500,000 for the period ending October 31, 1973."

On page 10, lines 14 and 15, strike out "June 30, 1974" and insert in lieu thereof "October 31, 1973."

On page 10, lines 18 and 19, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $13,000,000 for the period ending October 31, 1973."

On page 10, line 22, strike out "June 30, 1974" and insert "October 31, 1973."

On page 11, lines 1 and 2, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $4,000,000 for the period ending October 31, 1973".

On page 11, lines 5 and 6, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $55,000,000 for the period ending October 31, 1973."

On page 11, lines 9 and 10, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $52,500,000 for the period ending October 31, 1973."

On page 11, lines 13 and 14, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $4,330,000 for the period ending October 31, 1973."

On page 11, lines 17 and 18, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $750,000 for the period ending October 31, 1973".

On page 11, lines 20 and 21, strike out "June 30, 1974" and insert in lieu thereof "October 31, 1973.

On page 11, lines 23 and 24, strike out "June 30, 1974" and insert in lieu thereof "October 31, 1973."

On page 12, lines 3 and 4, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $1,500,000 for the period ending October 31, 1973."

On page 12, lines 7 and 8, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973 and $1,250,000 for the period ending October 31, 1973."

On page 12, lines 10 and 11, strike "June 30, 1974" and insert in lieu thereof October 31, 1974."

On page 12, strike lines 13 and 14 and insert in lieu thereof "for the year ending October 31, 1965 and each of the next eight years—".

On page 12, lines 17 and 18, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $52,500,000 for the period ending October 31, 1973".

On page 12, lines 21 and 22, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $30,000,000 for the period ending October 31, 1973".

On page 12, line 25, strike "June 30, 1974" and insert in lieu thereof "October 31, 1974".

On page 13, lines 3 and 4, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $500,000,000 for the period ending October 31, 1973".

On page 13, strike lines 6 and 7, and insert in lieu thereof "fiscal year ending June 30, 1971 and the next two fiscal years" and insert in lieu thereof "year ending October 31, 1971 and each of the next two years".

On page 13, lines 10 and 11, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $14,500,000 for the period ending October 31, 1973".

On page 13, lines 14 and 15, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $5,000,000 for the period ending October 31, 1973".

On page 13, lines 17 and 18, strike out "June 30, 1974" and insert in lieu thereof "October 31, 1973".

On page 13, lines 21 and 22, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $10,000,000 for the period ending October 31, 1973".

On page 14, lines 1 and 2, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $10,000,000 for the period ending October 31, 1973".

On page 14, lines 5 and 6, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $4,000,000 for the period ending October 31, 1973".

On page 14, lines 9 and 10, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $425,000 for the period ending October 31, 1973".

On page 14, lines 13 and 14, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $2,000,000 for the period ending October 31, 1973".

On page 14, lines 17 and 18, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $2,000,000 for the period ending October 31, 1973".

On page 14, lines 21 and 22, strike the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $3,330,000 for the period ending October 31, 1973".

On page 15, line 2, strike "July 1, 1974" and insert in lieu thereof "November 1, 1973".

On page 15, strike lines 6, 7, and 8, and insert in lieu thereof the following:

"(3) Section 794D(f)(A) is amended by striking the word 'fiscal' wherever it appears and by striking 'June 30, 1971' and inserting in lieu thereof 'October 31, 1971'."

On page 15, lines 11 and 12, strike out the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $85,000,000 for the period ending October 31, 1973".

On page 15, lines 16 and 17, strike out the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $5,000,000 for the period ending October 31, 1973".

On page 15, lines 21 and 22, strike out the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $33,000,000 for the period ending October 31, 1973".

On page 15, strike lines 23 and 24 and insert in lieu thereof the following:

"(b) Section 207 of such Act is amended by striking out 'June 30, 1973' and inserting in lieu thereof 'October 31, 1973'."

On page 16, strike lines 1 and 2 and insert in lieu thereof the following:

"(c) Section 221(b) of such Act is amended by striking out 'June 30, 1973' and 'July 1, 1973' and inserting in lieu thereof 'October 31, 1973 and November 1, 1973, respectively'."

On page 16, lines 5 and 6, strike out the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $20,000,000 for the period ending October 31, 1973".

On page 16, strike out lines 7 and 8, and insert in lieu thereof "and (2) by striking fiscal year ending June 30, 1967 and inserting in lieu thereof 'year ending October 31, 1967'."

On page 16, lines 10 and 11, strike "June 30, 1974" and insert in lieu thereof "October 31, 1974".

On page 16, lines 14 and 15, strike out the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $17,500,000 for the period ending October 31, 1973".

On page 16, lines 17 and 18, strike "June 30, 1974" and insert in lieu thereof "October 31, 1974".

On page 16, lines 21 and 22, strike out the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert

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in lieu thereof "for the fiscal year ending June 30, 1973, and $5,000,000 for the period ending October 31, 1973".

On page 17, lines 1 and 2, strike out the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $27,500,000 for the period ending October 31, 1973".

On page 17, strike out lines 3 through 6 and insert in lieu thereof the following:

"(j) Section 261(b) is amended by striking the word 'fiscal' everywhere it may appear and by striking 'June 30, 1971' and 'July 1, 1973' and inserting in lieu thereof 'October 31, 1971' and 'November 1, 1973', respectively."

On page 17, strike out lines 7 through 12 and insert in lieu thereof the following:

"(k) Section 264(c) of such Act is amended—

"(1) by striking the word 'fiscal' everywhere it may appear; and

"(2) by striking 'June 30' everywhere it may appear and inserting in lieu thereof 'October 31'; and

"(3) by striking 'July 1' and inserting in lieu thereof 'November 1'."

On page 17, lines 15 and 16, strike out the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $10,000,000 for the period ending October 31, 1973".

On page 17, strike out lines 17 through 20 and insert in lieu thereof the following:

"(m) Section 271(d)(2) is amended by striking the word 'fiscal' everywhere it appears and by striking 'June 30, 1972' and 'July 1, 1973' and inserting in lieu thereof 'October 31, 1972' and 'November 1, 1973', respectively."

On page 17, strike lines 21 and 22 and insert in lieu thereof the following:

"(n) Section 272 of such Act is amended by striking out 'June 30, 1973' and inserting in lieu thereof 'October 31, 1973'."

On page 18, line 2, strike out "July 1, 1974" and insert in lieu thereof "November 1, 1973".

On page 18, strike lines 3 through 8 and insert in lieu thereof the following: "Section 121(a) of the Developmental Disability Services and Facilities Construction Act (42 U.S.C. 2661) is amended by inserting immediately after the first sentence the following: 'There is authorized to be appropriated for the period July 1, 1973 through October 31, 1973, $7,000,000.'."

One page 18, lines 11 and 12, strike out the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $7,000,000 for the period ending October 31, 1973".

On page 18, lines 15 and 16, strike out the words "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "for the fiscal year ending June 30, 1973, and $45,000,000 for the period ending October 31, 1973".

On page 18, lines 19 and 20, strike out the words "each of the fiscal years ending June 30, 1973 and June 30, 1974" and insert in lieu thereof "the fiscal year ending June 30, 1973, and for the period ending October 31, 1973".

Mr. GURNEY. Mr. President, I ask for the yeas and nays on my amendment.

The yeas and nays were ordered.

Mr. GURNEY. Mr. President, I do not intend to take very long.

Mr. KENNEDY. Mr. President, may we have order in the Chamber?

The PRESIDING OFFICER. There will be order in the Chamber.

Mr. GURNEY. Mr. President, it is difficult to support the committee's proposal as it is currently written. It asks that we extend every one of some 44 health care programs for a full year at a total cost to the taxpayer of some $2.5 billion. It does this in the face of claims by the administration and by independent observers that a substantial number of these programs duplicate or overlap each other, or are outdated, inefficient ways by which to achieve particular health care goals. The committee arrived at its decision, initially, even before there were hearings on the bill. Now, a few weeks later, we see it on the floor again after just 1 day of hearings and one witness.

We simply cannot afford the luxury of delay which this legislation would allow. We fool ourselves if we think that Americans benefit from such a course of action. If money is wasted in inefficient or outdated health programs, then it is money lost that could have been used to meet society's more pressing health needs as well as other pressing needs. In effect, we face a double loss: First, a loss from what we fail to accomplish in meeting real health care needs. Second, we face a loss from what we are unable to accomplish in other areas—crime prevention, water or air pollution, and drug abuse for example.

I believe the committee's recommendation on this bill epitomizes one aspect of the conflict over the Federal budget now raging between Congress and the Executive. Who is going to assume responsibility for the efficient use of the people's money? Does the Congress have the discipline to marshall its decision-making powers in order to decide on the appropriate use of tax dollars? Must we continually have legislation through extension, with little or no review or change of existing programs?

The committee points out that these programs expire June 30, that they are important and vital and must be renewed, and that there is not time now to review them all in depth. In turn, the administration points out that they do not have all of their recommendations yet.

Thus it is said that we need time to evaluate these programs. That is a reasonable request, particularly in view of the myriad health care goals this legislation contains. But a full year? I do not think so.

I propose, and that is what my amendment does, that we extend the Public Health Service Act and Community Mental Health Centers Act for 4 months beyond the current expiration date, or until October 31, 1973. With the month of August lost to Congress because of the recess during that month, this amendment would still give us 6 full working months from now in which to evaluate these programs.

The issues for our deliberation have been clearly drawn in the administration's testimony. Do these programs work? Are there better ways to carry them out? Are there better sources of money or manpower than those provided by Federal resources?

Let me say, in addition to this—and then I shall be through—that I have had people come into my office in the last few weeks to talk to me about the bill. Some of them have told me that some of the programs we should pass. Some have also asked me not to make their names public, because they do not want to be "shot down" by their constituents. But they have actually told me they do not want these programs. Others have told me they need the programs vitally. Still others have said that we could probably cut back these programs and make them more efficient.

I would simply say that if there has not been time to prepare a specific bill and have it considered by the committee, why do we not, on this bill, take our time, until October 31, which will almost be the full working time that Congress may be in session this year, and come up with a bill that we can pass. That is what we ought to be doing with the public health programs. But let us do it with some real facts and real testimony to back our own position.

Otherwise we shall be going to the administration, saying, "No, we are not going to spend the money because we do not believe the programs are good." I say we have a chance for compromise. I am not asking anything more than to extend this program for 4 months or so, in which we can work out a bill.

Mr. DOMENICI. Mr. President, will the Senator from Florida yield?

Mr. GURNEY. I yield.

Mr. DOMENICI. I support the Gurney amendment. I think that yesterday, when I spoke before the Senate on whether we should engage ourselves in confrontation or accommodation, my remarks were squarely on the question that is before us today. I am certain that those who support this measure are aware of the fact that more time is needed to evaluate which programs should continue, which ones should be stopped, and what new ones should be started.

I concur wholeheartedly with the statement of the Senator from Florida with regard to how those involved in the programs are telling Senators that some of these programs are good, and some are not so good. I think as we go through this year—this transition year—when we are attempting to reenact old laws, old authorizations, and frequently even last year's appropriation measures, that, if we do accommodate them, some transition, not one which will indefinitely burden the beneficiaries of the laws, but one which will give the Senate time to pass better laws, America will be better.

I certainly think it is admitted, from the brief testimony before us, that there has not been enough time to evaluate the programs in the bill. If that is the case, perhaps there is justification to continue them rather than to terminate them.

I think the Senator from Florida offers an amendment that the Senate should subscribe to. Perhaps we should consider an amendment to give ourselves and the administration more time to decide what we should do.

I urge Senators to support the amendment of the Senator from Florida.

Mr. KENNEDY. Mr. President, I yield myself 5 minutes.

The Health Subcommittee in May of last year recognized that it would take them all winter to consider more than

50 pieces of legislation we are considering this afternoon which are included in the 12 extensions of the Public Health Act and the Mental Health Act. We invited Secretary Richardson of Health, Education, and Welfare to come before the Health Subcommittee in May of last year, so that we could take the whole of the period in the consideration of these particular proposals.

Secretary Richardson indicated that he was not prepared to come up, that the administration was in the process of formulating their programs. In September of last year, we asked Dr. DuVal, the Assistant Secretary of Health, Education, and Welfare for Health and Scientific Affairs, to come up and appear before the Health Subcommittee and give us his best judgment about these 12 proposals.

Dr. Duval testified that the administration did not want the Health Subcommittee to act, because we are going to have proposals in January and February of next year in connection with the President's budget.

So what did we do? Because we felt that we had a responsibility to act, we nevertheless incorporated seven of those proposals in a bill and submitted it to the Senate. The Senate passed S. 3716 by a vote of 78 to 0. But the House of Representatives did not act on it.

So we waited until January and February of this year, and what happened? The President's budget was sent up, but it did not include any specific legislated proposals. Mr. Weinberger then came before the committee, and we asked him, "Where are the proposals? We are ready to act now."

Mr. Weinberger said:

They will be up some time in February." But only last week, Mr. Weinbeger came before the Committee on Labor and Public Welfare, and we said, "Now, Mr. Weinberger, we want your proposals on the extensions of these various Acts. Will you give us your answer?

He said:

We are not prepared to give you an answer now. I cannot give you a specific date.

Mr. President, this legislation expires in June. But we have had virtually no cooperation from the administration since last May in respect to this vital legislation.

All we have done in the bill now before the Senate is take the identical dollar figures for fiscal year 1973 and continue these programs for the year. I have a number of substantive changes I would like to see made in the legislation and other members of the committee, Democrats and Republicans alike, have other changes, I am sure. But 15 out of 16 members of the committee supported the idea of a simple extension in order to give the Congress time to act.

I as chairman and they as members of the Health Subcommittee, Democrats, and Republicans alike, decided that we would begin forthwith to consider the whole range of the legislation. Because it is a massive job, Mr. President, it will require a year for consideration and action. That was recognized by the committee itself. So 4 months will not be the answer.

The second question is: How can we support the proposal of the Senator from Florida when he is unable to give us any idea, this afternoon, of what the administration's position will be on any of these proposals? He is not saying, "If we only give them 4 months, I have all the different proposals here in my back pocket this afternoon, and the committee can consider them between the end of March and the end of the 4-month extension, and act responsibly."

He cannot do it, because of the 12 proposals we are considering, there is only one on which the administration has spoken, and that is on the extension of the Medical Libraries Act. There has been no indication that the administration would come up at any time and give us their views on the other extensions, except for those authorities they wish to terminate.

Finally, let me say this: We know that the appropriations are made by Congress on an annual basis. What is the Appropriations Committee going to do with a 4-month extension? It would be virtually impossible to consider it. A 4-month extension on these various proposals, with all that means in terms of the appropriations process, would obviously mean the strangulation of this legislation. And let me say quite frankly, I sincerely believe that that is the position of the administration on a number of these authorities.

On the regional medical program, the community mental health centers program, the Hill-Burton program, the public health training programs it is clear that the administration is interested in ending the authorities. They would do this even over the very wide-ranging, strongly objecting positions which have been stated by a wide variety of groups, including the National Institutes of Health, people involved in the mental health areas, and other distinguished researchers in health fields.

For all those reasons, Mr. President, I hope the amendment will be rejected by the Senate.

I have indicated to this body, on behalf of the members of the health subcommittee, that we are prepared to act. We are hopeful that in the consideration of this legislation, which will surely take a full year, that we will obtain early reports from the administration, so that we can work, to the extent that that is possible, in a constructive and positive manner.

The PRESIDING OFFICER. The Senator's 5 minutes have expired.

Mr. KENNEDY. Mr. President, I reserve the remainder of my time.

Mr. GURNEY. Mr. President, I yield 5 minutes to the distinguished Senator from Colorado.

Mr. DOMINICK. Mr. President, I take the floor, I might say, with some reluctance, because I have supported the pending bill in committee on two occasions, and I believe, if I am not mistaken, that I am a cosponsor of it. I am not sure, but I think so.

The PRESIDING OFFICER. The Senator is correct.

Mr. DOMINICK. The thing which bothered both the Senator from Massachusetts and me during these hearings and indeed all the way through is that we had no alternative. We did not have time enough, we both felt, to be able to go over these programs one by one and decide for ourselves whether they ought to be extended, changed, or modified in any way.

Hearing about the fact that there was to be no more funding, for example, on the Hill-Burton Act, I put in a provision for a 3-year extension of it, but with some changes—changes providing that no new bed hospitals would be built unless they received the approval of comprehensive health planning which, in a given area, would determine where beds were needed and where they were not. I hope we can come to some kind of hearing on that proposal relatively soon. Other Members of Congress are arriving at other proposals on their own initiative.

It would strike me that some argument could be made for the positions the administration has taken on programs that have worn out their usefulness. The nonfunding of the Hill-Burton Act was largely based on the fact that we have more beds than we need now.

That is true only in certain areas. It is not true in other areas. There are many areas, even in my own State, in rural communities, where aid and assistance are needed for adequate hospital facilities.

We also still have need for updating, modernization, improvement, and the application of new technology in hospital systems. So there are a great number of needs in the health interests of the people of our country which I think we should go forward with, with a variety of changes in the existing programs, but making those changes congressionally, and not just cutting off the whole idea.

The question is: Do we need to continue the existing programs for a whole year? That is what this amendment is about.

It seems to me that between now and the end of October, which would be the period of time provided under the amendment of the Senator from Florida, giving us a total of not 4 months, but 7 months, the Health Subcommittee of this body and the health subcommittees in the other body could easily prepare and put together a number of proposals in a number of different areas, which would then be up for funding before the Appropriations Committees, without having to leave the whole thing hanging in limbo for a year. Therefore, I intend to and will support the Senator from Florida on his proposed extension.

Congress, whether it be the Senate or the House of Representatives, can act promptly. We have done it in the past, both in committee and on the floors. Seven months, after all, is quite a long period of time for review and for modernization of those programs when needed.

A typical example which I mentioned in my opening statement, when this funding was brought up today, is the regional medical planning programs. Those programs, although they have been of use in some areas of the country, have been of no use in other areas of the country. A great number of them have

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been used in order to channel funds in, and in order to provide continuing education for the doctors. That is of help in some instances. In many areas it is not. Moreover, it can be done through other programs.

It would seem to me that we could, piece by piece, look these matters over as we go along and make the changes before the 7-month period has expired.

For that reason, I am happy to support the Senator from Florida and urge the adoption of his amendment.

The PRESIDING OFFICER. Who yields time?

Mr. TAFT. Mr. President, I yield myself 5 minutes on the bill. I take this time on the bill because I think it is particularly appropriate to discuss the arguments which I would present on the bill on the Gurney amendment.

I would like to say at the outset that I strongly support the Gurney amendment, and I feel it is wholly consistent with the positions I have taken on the bill, which I set out in the minority views on page 95 of the committee report.

We had in the committee just 1 day of hearings on this bill, during which the only administration witness was the Secretary of HEW. The Secretary was pinned down in question on that day on two or three of the subjects pretty largely covered by the bill, and especially the community mental health centers programs. There really was little done getting into policy decisions which are behind the decisions reflected in the budget.

It is interesting to note that we hear much said about how the Executive is taking over the authority and prerogative of the legislative branch of the Government. Yet, so far, here, the committee is so helpless, apparently, to act on these programs itself, that after a couple of years of knowing that changes were anticipated—and I think, to be realistic, knowing that the changes would be made—the committee itself failed to come forth with one serious piece of legislation in this area.

The complaints now being made, that the administration has not come up with its legislative recommendations, it seems to me the committee itself has a responsibility for coming up with legislative recommendations, particularly under those circumstances.

It is perfectly all right to wait and ask for information from the department, and for suggestions from the department, but particularly with Congress in the unreceptive mood it is today, insofar as the recommendations of the Executive are concerned, and I do not think we should be sitting around waiting for the recommendations of the Executive on programs that we think should be changed. Of course, in the budget and in the recommendations of the administration, we know what the administration's position is on a number of programs, and the number they think should be discontinued, so why have we not been having hearings and listening to witnesses on those particular programs? We know they will recommend that they be discontinued.

If we take the Gurney amendment approach, and add on an additional 4 months, which is desirable, we can at least do that and then take a look at the programs we know the administration wants to discontinue and decide whether they should be continued or discontinued, which we can do by holding hearings and listening to witnesses and making our decision as to what the proper legislative process is. But to give a blanket extension at this time would be a great mistake. That is what the bill attempts to do.

But the accusation that because, somehow, the administration, by not coming up with recommendations as to continuing authorizations covered in one way or another substantively in the budget recommendations, is somehow trying to legislate by extension or by cutting off in the budget, I would reply to that by saying that that is what is being attempted to be done here, and what is surely being attempted to be done in other programs which, in effect, is legislation by simple extension of authority without looking into the substance of a particular measure.

We should take a look at the substance. The Secretary of HEW did do a good job of explaining the general position. We can develop from this numerous guidelines because there was no committee report available at an early date, at least until today. On March 22, I did insert into the RECORD, on page 9078, a statement by Secretary Weinberger before the committee last week, talking about these programs. He pointed out at that time, and I repeat here, some of the discussion with regard to the particular programs and with regard to the overall proposal of the bill to extend authorizations blindly in what I would call a log-jam or a pig-in-a-poke approach to the probem.

The authorizations come to about $2 billion more than $1 billion of the 1974 budget request. Some of these authorizations, including comprehensive health planning, health services, research and demonstration, and medical libraries support, would continue to be funded under the President's 1974 budget.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. TAFT. Mr. President, I yield myself an additional 5 minutes under the bill.

The PRESIDING OFFICER. The Senator from Ohio is recognized for 5 additional minutes.

Mr. TAFT. Mr. President, let us take a look at some of the programs in which there has been a phaseout, termination, or reduction, as suggested by the administration.

The first is the Hill-Burton program. It is admitted, as the Senator from Colorado (Mr. DOMINICK) very soundly pointed out, that the Hill-Burton program, in many respects, has outlived its usefulness, as in many areas there is a surplus of hospital beds, yet they are continuing the building of more hospital construction programs without relation to the needs of where they are. So that it seems to me very unfortunate to do that. Let us not kid ourselves. If we do not face up to the situation and put a deadline on ourselves other than the mere additional year on us, I doubt whether we will see in this Congress—never mind in this year—any major changes in the Hill-Burton program. Especially coming from a large State, which I think is getting unfavorable treatment under the Hill-Burton program, I particularly feel that we should be taking a hard look at this problem, examine it closely, and come up with a better hospital program, to put it on a fair basis where distribution of funds are concerned, and direct our efforts with regard to facilities in those areas where the facilities are most needed.

As to the regional medical programs, the position of the administration is perfectly clear. Its position is that the greatest percentage of the funds has gone to finance the continuing education of health professionals who, in many fields, could possibly provide for their own support, which they are building up for their own professional competence.

There are other funds under which, in various ways, they are funded. It seems to me that on the regional medical programs, we should be able to come to a pretty quick conclusion, that the committee, with a few days of hearings as to whether we think the regional medical programs should be funded or should not be continued, either way.

I do not see any reason to put this off for a year. Four months is ample time in which to make sensible recommendations on the part of the Senate.

As to the categorical allied health program, Federal support to institutions training subprofessional health personnel will be targeted on innovative projects under the flexible authorities of the existing Comprehensive Health Manpower Act. We should have hearings and the committee should be able to fund and authorize it under continuing legislation that would be authorized by this particular bill.

As to the community health centers program, the Secretary has been specific in his testimony in that regard, and the fact that the administration's position is that the community health centers programs concept, which is a demonstration project, has run through the demonstration phase, and that we will, because the commitments were made for 8 years, be funding existing health services, set up on a phasing-out basis as originally planned, but the demonstration is completed and we should make a decision whether further demonstration is needed or whether some general community health center plan financed by the Federal Government for all communities in the United States is the proper way to go. We should undertake the responsibility of looking into this.

These are some of the factors that should be considered when we take a look at this legislation today, although it seems to me that it is doubtful, or wise, blindly to extend the program for an additional year and say we cannot put off the decision another year and then come around and take a look at it again because the administration did not come up with some proposal and we agreed to it right away. The far more sound approach is to take that of the Senator from Florida and extend the proposal at least

for an additional 4 months to see whether we can attack it piecemeal. There is no need for all the items to be in one particular bill. They are separate programs and basically they can be handled and considered separately. The committee should take the responsibility to do just that. The proposal of the Senator from Florida is a sound proposal and one that deserves the support of the Senate. As to the support, I, for one, will maintain the position I took in committee, that I think the committee should measure up to its responsibilities. I am not going to vote for it merely as an extension program without looking at the merits, or taking the responsibility of taking care of the health programs of this country.

The PRESIDING OFFICER. The time of the Senator from Ohio has expired.

Mr. KENNEDY. Mr. President, the arguments I have heard here this afternoon by the Senator from Ohio have an Alice in Wonderland quality. It was the Secretary of HEW who said in the spring of last year that, because the administration did not have its proposals sufficiently perfected, we should wait and delay. To accommodate the Republican Secretary of HEW, we did so. Then Mr. DuVal came up, and he said:

> We do not want to extend various proposals. We will have our own proposals in January or February.

So, out of consideration for the Assistant Secretary of HEW, we withheld any action on some of them. We acted on seven programs, which actually passed in the Senate. Mr. President, I can give assurance to my friend from Ohio that the administration did not give us any proposals at all on any of these programs. We will have a proposal before the Senate next year on every one of these proposals, either with or without the objection of the administration: But we cannot allow ourselves to be put in a position where the Secretary of HEW asks us to wait for their recommendations, where the Assistant Secretary of HEW asks us to wait until January or February of this year, where the new Secretary of HEW asks us to wait; and now we find ourselves at the end of March with no action yet on basic programs that are expiring.

Now we hear from the Senator from Ohio, "What has been wrong with the committee?" We have been trying to accommodate the position taken by two different Secretaries of HEW and the Assistant Secretary of HEW. We have done our best to accommodate them. But now we are going to act.

For that reason, I hope the Senate will give us the kind of time we need, in order to consider these matters the way they should be considered. I hope the Gurney proposal will be defeated.

Mr. President, I yield back the remainder of my time.

Mr. GURNEY. I yield back the remainder of my time.

The PRESIDING OFFICER. All time on the amendment has been yielded back.

The question is on agreeing to the amendment of the Senator from Florida. On this question the yeas and nays have been ordered, and the clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. ROBERT C. BYRD. I announce that the Senator from Louisiana (Mr. JOHNSTON), the Senator from Maine (Mr. MUSKIE), the Senator from California (Mr. TUNNEY), and the Senator from New Jersey (Mr. WILLIAMS) are necessarily absent.

I also announce that the Senator from Mississippi (Mr. STENNIS) is absent because of illness.

I further announce that, if present and voting, the Senator from New Jersey (Mr. WILLIAMS) would vote "nay."

Mr. GRIFFIN. I announce that the Senator from Massachusetts (Mr. BROOKE) is absent by leave of the Senate on official business.

The Senator from Wyoming (Mr. HANSEN) is necessarily absent.

The result was announced—yeas 37, nays 56, as follows:

[No. 65 Leg.]

YEAS—37

Baker	Domenici	Pearson
Bartlett	Dominick	Percy
Beall	Fannin	Proxmire
Bellmon	Fong	Roth
Bennett	Goldwater	Saxbe
Brock	Griffin	Scott, Pa.
Buckley	Gurney	Scott, Va.
Byrd, Harry F., Jr.	Helms	Stevens
	Hruska	Taft
Cook	Mathias	Thurmond
Cotton	McClure	Tower
Curtis	Nunn	Young
Dole	Packwood	

NAYS—56

Abourezk	Gravel	McGovern
Aiken	Hart	McIntyre
Allen	Hartke	Metcalf
Bayh	Haskell	Mondale
Bentsen	Hatfield	Montoya
Bible	Hathaway	Moss
Biden	Hollings	Nelson
Burdick	Huddleston	Pastore
Byrd, Robert C.	Hughes	Pell
Cannon	Humphrey	Randolph
Case	Inouye	Ribicoff
Chiles	Jackson	Schweiker
Church	Javits	Sparkman
Clark	Kennedy	Stafford
Cranston	Long	Stevenson
Eagleton	Magnuson	Symington
Eastland	Mansfield	Talmadge
Ervin	McClellan	Weicker
Fulbright	McGee	

NOT VOTING—7

Brooke	Muskie	Williams
Hansen	Stennis	
Johnston	Tunney	

So Mr. GURNEY's amendment was rejected.

PROGRAM

Mr. SCOTT of Pennsylvania. Mr. President, I rise to inquire of the distinguished majority leader the program for the remainder of the day, and beyond.

Mr. MANSFIELD. Mr. President, will the Senator from Massachusetts yield?

Mr. KENNEDY. Mr. President, I yield 5 minutes on the bill to the majority leader.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. MANSFIELD. Mr. President, in response, may I say that it is anticipated that very shortly the vote on final passage of the pending business will occur.

The distinguished Senator from Louisiana (Mr. LONG), the chairman of the Committee on Finance, would like to have the Senate take up H.R. 3577, an act to provide an extension of the interest equalization tax, this evening. He does not think it will take too long. There is an expiration date of Saturday. If we do not finish that measure tonight—we will not stay in session too late—it will be carried over until tomorrow.

That measure will be followed, in turn, by H.R. 1975, an act to amend the disaster relief bill, and that, in turn, will be followed by the bill to amend the Par Value Modification Act, S. 929, and that, in turn, will be followed by the five bills on crime reported by the Committee on the Judiciary.

Mr. McCLELLAN. Mr. President, if the Senator will yield, what day will that be?

Mr. MANSFIELD. Later in the week, if we get to it. We will try to give the Senator at least 1 day's notice.

Mr. SCOTT of Pennsylvania. As to the vote on whether or not the veto of the President will be sustained or not on the Vocational Rehabilitation Act, what is the plan for calling up that measure?

Mr. MANSFIELD. Next Tuesday, at a reasonable hour.

Mr. SCOTT of Pennsylvania. This is notice, then, to Senators that it will be Tuesday afternoon and we are trying to accommodate as many Senators as possible by virtue of this early notice. Tonight, I believe, is the reception being given by poultry fanciers, but I take it we have an obligation to do our duty here.

Mr. MANSFIELD. It all depends on whether the egg or the chicken came first—well, that is it, anyway.

PUBLIC HEALTH SERVICE ACT EXTENSION OF 1973

The Senate continued with the consideration of the bill (S. 1136) to extend the expiring authorities in the Public Health Service Act and the Community Mental Health Centers Act.

Mr. KENNEDY. Mr. President, does the Senator yield back the remainder of his time?

Mr. JAVITS. I yield myself 1 minute on the bill.

Mr. President, this is an essential bill. We will do our utmost to resolve each of these measures by proper consideration that the course of time and this bill allow.

Mr. President, the reason for my strong support for the Public Health Service Assistance Extension of 1973 (S. 1136), of which I am a cosponsor along with 15 of the 16 members of the Labor and Public Welfare Committee, was set forth in detail on March 8, 1973, in my remarks in support of its immediate consideration by the Senate.

The bill now under consideration has one purpose: To reaffirm the intention of Congress that the Congress will determine whether and which of the health programs extended for 1 year by the bill will continue. Executive budget action which has let certain health programs wither, vanish, or be effectively terminated by lack of adequate funding, is not the appropriate mechanism to determine

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the fate of vital substantive health programs affecting millions of Americans.

It is entirely possible that, in the words of Secretary Weinberger when he testified before the Committee on Labor and Public Welfare:

> If the Congress and its responsible Committees were carefully to examine each such authority in light of its relative priority in the competition for scarce Federal dollars, it would agree with the Administration that many of these authorities should be allowed to terminate on June 30, 1978.

But the evidence regarding the need for the programs' fiscal life or death must be fully developed and documented for the Congress by the Executive. The Executive power of the purse—through zero budget appropriations requests or requesting funding support for expiring programs—should not determine what laws Congress shall pass, and how they shall be implemented. Congress is and must continue to be an equal partner in the process of determining the future for programs affecting the American people.

The Executive should be checked and balanced by the Congress, which is also of the people's elected officials. That is the genius of the American political system. I believe that is the way we should proceed, rather than upon action taken solely by the President.

The complexity of the task before the Congress in evaluating and making its will known in regard to the more than 50 separate sections of law affecting nearly every facet of current Federal support of the Nation's health care system is enormous. The committee's determination and commitment to move as rapidly as possibly to permit Congress to rationalize these legislative authorities in a manner consistent with the appropriate Federal role in respect to the health needs of the American people is, I believe, documented by its past performance, as detailed in the committee report on the pending bill.

Let us turn to just those health programs Secretary Weinberger has testified the administration is proposing to phase out or terminate—community mental health centers, Hill-Burton, and regional medical programs—and to those proposed for redirection such as comprehensive health planning and services.

In regard to the latter, there has been no legislative proposal submitted to the Congress. All that can be gleaned is Secretary Weinberger's generic testimony and what the administration has proposed in the 1974 budget. In essence, a determination to utilize expiring section 314(e) of the Public Health Service Act for funding programs the Executive chooses to support. I am concerned that the Executive has failed to recognize what Congress has made crystal clear in regard to such proposed action. Only last year the Congress passed and the President signed into law, Public Law 92-449. The legislative history of section 314(e) is enunciated in Senate Report 92-285, where in discussing this section of the law it cites the House Committee on Interstate and Foreign Commerce in its report on the Communicable Disease Control Amendments of 1970:

> In each of its budget presentations each year since the enactment of section 314(e), the Department of Health, Education, and Welfare has earmarked specific amounts of the 314(e) fund request for specific programs for the coming year. In other words, the categorical grant approach has continued since the enactment of Public Law 93-749, except that instead of the Congress setting the categories, the categories have been set by the Department of HEW.

One of the purposes of this bill is to restore some control to Congress of the categories of health programs for which project grant funds are to be made available.

The Senate Labor and Public Welfare in respect to this matter in its report on the Health Services Improvement Act of 1970 stated:

> The Committee notes with concern the fact that a large proportion of the programs funded under section 314(e) continue to be too narrowly focused rather than focused upon the broader area of the organization and delivery of health services.

In regard to the programs the Executive has recommended for termination:

First. Hill-Burton: I have long indicated my dissatisfaction with the grant allocation formula of the program and the need to redirect this program to meet the $12.7 billion needs of modernization and upgrading of outmoded and overburdened public hospitals—whose lives are in a fiscal crisis—and for emphasis to be put upon innovative outpatient treatment facilities that might keep many out of the expensive hospital treatment setting. Hospital new bed construction is but one facet of this program and in response to Secretary Weinberger's "a special Federal grant program for hospital construction is now unwarranted," I would suggest the Congress may wish to consider how the program could be modified by, for example, certificate of need legislation and strengthened with more effective comprehensive health planning and regional medical program overview.

Second. Community Mental Health Centers: I would agree with Secretary Weinberger that "this program has proven itself," but Congress has no evidence that without Federal assistance we can establish what to date Congress has strongly supported, "rationalize these legislative authorities in a manner consistent with the appropriate Federal role in respect to the health needs of the American people." In this regard, I would like to share with Senator SCHWEIKER his concern—which he expressed at the hearing on the pending bill—about Secretary Weinberger's interpretation of the community mental health centers program as "demonstration." I find nothing in any of either the House or Senate reports on this legislation, since its renewal in 1965, 1967, 1970—or Senate passage in 1972—which permits of an interpretation of CMHC's as a "demonstration" program. Until the Congress has sufficient evidence to prove that localities will undertake to bring CHMC services to their people, I believe Congress should provide appropriate Federal funding support.

Third. Regional Medical Programs: I am not convinced that the Executive's dissatisfaction about regional medical program's seemingly ill-defined or amorphous role and corollary searching for more specific missions—which in many instances I share—is sufficient reason for Congress to terminate the program. There are 56 functioning regional medical programs, nationwide coverage having been achieved by 1968, and their capabilities, missions, and achievements vary. But if, as alleged, all have not been programs of excellence, this does not mean—unless somewhere there is documentary evidence, which I have not as yet had made known to me, to the contrary—that the entire regional medical program should be terminated rather than have Congress work its will in determining how the program can most effectively be utilized in assuring that all our citizens have equal opportunity for quality medical care.

Mr. President, this brief overview of the complex issues which must be considered in any serious congressional fundamental review and evaluation of the programs encompassed in the pending measure makes it clear why Congress should pass this bill and preserve its prerogatives and priorities, rather than permit Executive action alone to be the determining factor.

In closing, Mr. President, I should like to assure concerned citizens that the 1-year extension of the Developmental Disabilities Services and Facilities Construction Act is in no way an indication of my support for the existing law's definition of "developmental disabilities." My commitment to broadening the definition—as I indicated during hearings on that measure—has not abated. Nor, does my support of this measure mean I will in any way diminish my efforts and work to establish a national commitment for a "bill of rights for the mentally retarded." I feel strongly that the "bill of rights for the mentally retarded" should be enacted into law this year.

Mr. KENNEDY. Mr. President, I yield back the remainder of my time.

The PRESIDING OFFICER (Mr. BARTLETT). The question is on agreeing to the committee amendment, as amended.

Mr. KENNEDY. Mr. President, a parliamentary inquiry.

The PRESIDING OFFICER. The Senator will state it.

Mr. KENNEDY. Have the yeas and nays been ordered?

The PRESIDING OFFICER. No, they have not.

Mr. KENNEDY. I ask for the yeas and nays.

The PRESIDING OFFICER. Does the Senator ask for the yeas and nays on the amendment or on passage?

Mr. KENNEDY. On passage.

The yeas and nays were ordered.

The PRESIDING OFFICER. The question is on agreeing to the committee amendment, as amended.

The amendment, as amended, was agreed to.

The bill was ordered to be engrossed for a third reading, and was read the third time.

Mr. HELMS. Mr. President, I approach consideration of this bill with great con-

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cern that we may be misleading the American people as to the future of the Federal Government's role in supplying tax funds for health services and medical facilities.

The false expectations which may be created by the passage of this bill are, I feel, accurately outlined in the minority views to the committee report, authored by the distinguished junior Senator from Ohio (Mr. TAFT).

I feel it is essential during this Congress that the Senate make a positive effort to consolidate and supply a reasonable perspective to the existing legislative authorities in this area. This is absolutely imperative, Mr. President, if we are to arrive at a more appropriate Federal role in the total effort to provide for the health needs of all the American people. This is why it is especially discouraging to note that the committee has reported out a blanket extension for all the existing programs. It is imperative that we discriminate between those programs with merit and those without merit, if we are to make positive changes in our health care delivery system.

Mr. President, the committee's own report recognizes the need to upgrade, improve, and, in some cases, eliminate provisions in the existing Federal programs relating to health care. How then can we, as responsible legislators, rationalize the authorization of more than $2 billion to continue for 1 year, programs which are admittedly deficient, if not in some cases totally unnecessary?

There is a tremendous inertia inherent in large-scale Federal programs which extensions, such as the one we are now considering, only tend to reenforce.

I earnestly look toward the committee for the legislative initiative to deal with these programs in a substantive way and report out to the Senate constructive alternatives to the present health care programs. In the meantime, I cannot justify a vote for the status quo in the face of such a pressing need for change.

Mr. President, I ask unanimous consent that the minority views of the distinguished junior Senator from Ohio (Mr. TAFT), be included at this point in the RECORD.

There being no objection, the minority views were ordered to be printed in the RECORD, as follows:

MINORITY VIEWS OF MR. TAFT

In a very short span of time—one day of hearings—during which the Administration was the only witness, the Committee reported S. 1136, a bill to extend umbrella protection for some forty-five health programs. This protection insures that all of these programs, due to expire June 30, 1973, will continue for another year regardless of whether or not they have proven to be worthwhile.

What this bill is attempting to do is to buy more time, at a $1.8 billion price tag, to study the desirability of further extensions. In reality, it is not buying time but is pointing out an agonizing fact that we as a Committee have not done our job. If we had, there would be no need for a blanket, automatic, one-year extension.

In the last Congress the Committee reported a similar bill on August 16, 1972. In the Committee report, several members stated in *Additional Views* that there was ample time to explore the question of a change in the Hill Burton formula prior to that program's expiration date, June 30, 1973. Yet here we are, seven months later, asking for more tomorrows, which brings me to the crux of my objection.

My objection to reporting this bill was not based on the difference with the Committee over the wisdom of extending one or another of these programs. Doubtless, some of them should be continued and others should not. However, the Committee has taken the course to legislate through extension rather than face the task of scrutinizing these programs and making judgments on the merits, even though we have three months in which we could do so. Such a course serves only to prolong the anxiety and confusion of those affected in the field.

I recognize that this scrutiny will be difficult, but I also recognize that when we entered this legislative body that all decisions facing us would not be easy or popular. Yet such decisions must be made, and in my judgment an automatic one-year extension of these programs to prevent a so-called "log jam" is poor justification for this type of legislating.

ROBERT TAFT, JR.

Mr. DOLE. Mr. President, over the past two decades Congress has enacted a great number of health programs to improve health care in America. Many of these programs still operate efficiently and effectively and perform vital roles in the Nation's total health care system. Yet some health programs have proven less effective than originally expected or have accomplished their intended purpose.

I am sure my colleagues agree there is a need for a comprehensive review of the the Nation's various health programs. Yet the task of sifting through the ongoing health programs to determine which should be extended and which should be deleted is not simple or clear-cut. Many factors often cloud the issue in any individual program so its effectiveness or ineffectiveness might not be immediately apparent. For example, it is difficult to judge the effectiveness of a program on a national scale when some programs are naturally more effective in urban areas and others are more productive in a rural setting. In many cases, efficient administration and community participation in a health program will make it effective in one community or State while it is a complete failure somewhere else where leadership and community involvement are lacking. Thus, the value of a program cannot always be assessed by viewing limited examples of its operation.

TIME FOR EVALUATION

To properly evaluate the performance of our existing health programs and formulate constructive alternatives, Congress must study in depth the impact of existing programs in individual communities and their combined effect on the Nation as a whole. We must analyze alternative and better means of coordinating the existing facilities and programs, so a stronger basis is established for developing a more comprehensive system of health care.

This comprehensive analysis requires time—time to thoroughly analyze the ongoing programs and ample time for planning any change in Federal funding arrangements. By providing advance notice of the changes in these programs, those now dependent on Federal assistance which is to be terminated can seek alternative sources of funding from local and State sources. In many instances, an additional year of Federal aid will enable many of the programs currently dependent on Federal funds to become self-supporting.

Because present time requirements do not permit a thorough congressional analysis of the health programs which expire June 30, and because alterations in these programs at this late date would stifle the efforts and erode accomplishments of many individuals and communities who have been working successfully under existing programs, I, today, support S. 1136, the 1973 Public Health Service and Community Mental Health Centers Extension Act.

S. 1136 extends the 44 expiring program authorities under the Public Health Services and Community Mental Health Centers Acts in order that the existing health programs may be continued during a period in which Congress considers more comprehensive legislation and program reform. I support the floor amendment which grants a 4-month extension of the authorities since I feel this is adequate time for Congress to take appropriate action. However, should that amendment fail, rather than see the existing programs terminate June 30, I will support the 1-year blanket extension proposed in the committee bill. The 1-year blanket extension will provide more adequate time for a thorough analysis of existing programs, permit comprehensive new programs to be considered, and establish a transition period during which new avenues of Federal support can be studied and local and State support examined so that accomplishments under the existing programs will not be lost due to an abrupt cessation of funds.

KANSAS REGIONAL MEDICAL PROGRAM

Several programs valuable to Kansas would be seriously damaged if the existing authorities are not extended and Federal funds are not made available for their continuation beyond June 30 of this year. The regional medical program authorized under 901(a) of the Public Health Services Act is one program due to expire June 30, 1973, if action is not taken. The regional medical program—RMP— has been under fire in many sections of the country and in some instances the attack has been justified but the Kansas RMP has proven to be one of the most effective programs in existence for upgrading health care in the State and improving the delivery of health services, especially in rural areas.

During the past 6 years, the KRMP has invested nearly $8 million in efforts to improve health care of the people of Kansas. The University of Kansas Medical School, acting as the Federal grantee, has contracted with over 20 institutions and organizations across the State to assist them in carrying out specific project activities to improve the availability of quality health care in that community.

IMPROVING RURAL HEALTH CARE

One of these programs, the nurse clinician program, has helped meet some of the problems created by the rural doctor shortage which exists in many parts of the State. Under this program participating nurses undergo 8 weeks of inten-

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sive classroom work and 10 months of internship. The nurse clinician is then placed in a community under the supervision of a physician and assists the physician by relieving him of some of the routine office procedures, assisting in emergency situations, making house calls, and administering to patients under the doctor's supervision. The nurse also helps take histories, assists in physical examinations and diagnostic tests, and helps manage chronic disease patients such as those suffering from arthritis and diabetes. Through the use of these paramedical skills, medical services are being expanded and extended into the home, and in some instances the nurse clinician is being utilized to expand medical services in a previously doctorless community.

The nurse clinician program is operated through Wichita State University and since its inception in 1972 has enrolled 29 nurses. By June of 1973, the nurse clinician program will be serving 23 counties in Kansas. The average cost per trainee is approximately $2,750 and each clinician is estimated to increase a single physician's capacity by 30 percent.

KRMP has also made substantial progress toward the goal of bringing advances in medical knowledge to the bedside of Kansas patients. Physicians and nurses have received special training and developed skills in the latest techniques for acute coronary care, pulmonary disease care, cancer care, and renal dialysis nursing. Other KRMP funds have been utilized to develop a cancer information center to handle data on cancer patients in the State, and a library system linked to field offices in Great Bend, Wichita, and Topeka, which is used to provide immediate medical access to library resources for health professionals across the State.

EMERGENCY MEDICAL CARE

KRMP has led the way in developing an emergency medical service system for Kansas. In cooperation with the department of family practices at the University of Kansas Medical School, KRMP assisted in training 1,360 emergency medical service personnel including 330 Kansas highway patrolmen and 1,030 firemen, law enforcement personnel, and ambulance attendants to improve their skills and assist their effort to reduce the mortality rate due to trauma and other medical emergencies. In conjunction with the State department of health and the Governor's Commission on EMS, KRMP has developed a comprehensive statewide emergency medical service plan to provide better emergency care to all residents of the State.

I am currently a cosponsor of a bill which would assist this State effort by making available military transportation and medical equipment for emergency services around the military bases in Kansas. This bill, S. 31, would authorize the Secretary of Defense to utilize Department of Defense resources for the purpose of providing medical emergency transportation service to meet the needs of civilians living in the community around existing military bases. This expanded utilization of the military medivac teams to meet civilian needs should be a matter of priority consideration now that the military demands for their services have diminished, and I would hope that the Armed Services Committee can give S. 31 prompt attention and favorable consideration.

LOCAL HEALTH MANPOWER TRAINING

Five health services/educational activities have also been established across the State by KRMP. They have the responsibility of identifying local health manpower needs and developing local training opportunities for local talent. Programs offered through Fort Hays State College, Colby Community College, Marymount College, Washburn University, and Wichita State University analyze the needs of health facilities and practitioneers in various communities and train local health personnel who are interested in serving in that particular community.

Other innovative programs sponsored by KRMP have established nurse clinics in seven small towns in Ottawa County in association with the resident physician in the county seat to improve health care delivery in the county. In Wichita, a program was established to help juvenile diabetics deal with the everyday problems of diabetes. In Great Bend, a comprehensive educational program retrained and reactivated 72 nurses.

I bring these programs to the attention of my colleagues for two reasons.

First, to illustrate the effectiveness of the RMP in Kansas and to show the severe impact on health services in Kansas which would result if an abrupt termination of Federal funding of the program occurs at this time. But in addition, I feel the KRMP programs reveal the potential for improvement in health care in Kansas which is possible with better utilization and organization of existing medical resources, KRMP programs have been inexpensive and at the same time have proven the efficiency and effectiveness of improving our existing medical care system. They appear to be a vastly preferable alternative to total replacement of our existing system with a $100 billion a year federally controlled program whose performance potential is unknown and whose cost in taxes to the American public is equally uncertain. I, therefore, ask my colleagues to join in support of the RMP as practical and efficient means of improving our national health care program by building on the solid base which already exists. The administration has expressed the belief that the Federal Government should assume a more limited role in the health care field with emphasis on special finances for structural changes in the health care system either by providing new facilities or demonstrating new types of delivery systems. I can think of no better example of a limited amount of Federal money having greater impact on the development of new techniques for improving health care delivery than has been recorded by the operation of the RMP in Kansas.

COMMUNITY MENTAL HEALTH CENTERS

S. 1136 also extends the authority of the Community Mental Health Centers Act whose programs are vital to quality health care in Kansas. As a nation, we are just beginning to recognize the importance of a total health care program—one which provides for the mental as well as physical well-being of our citizens. The community mental health centers play a vital role in the health care picture and in the lives of a great many Kansans. Before MHC's were established in Kansas, mental health care was available only in a few cities. This meant that those in rural Kansas had to seek services far from their homes and were often placed on waiting lists, because of overcrowded conditions in State facilities. Now with community mental health centers in nine communities across the State, Kansans are able to receive outpatient care and guidance before extremely serious problems evolve.

This ounce of prevention has proven to be worth a pound of medicine by providing clinical and consultative mental health services through the community health centers, costly and ineffective long-term and custodial care in State mental institutions has been reduced. Since community mental health centers have been established in Kansas, the number of people requiring services from State institutions has dropped considerably while the number of people receiving mental health assistance has steadily increased.

The mental health care centers in Kansas have provided care for those in need of the services at rates they can reasonably afford. However, if Federal staffing and consultative service funds are discontinued after June 30, 1973, the availability of these comprehensive services to a large portion of the population will be threatened. The High Plains center which serves the northwestern portion of the State will be forced to drastically reduce its services if the Mental Health Center Authority is not extended. This will mean that many northwest Kansas residents will be without mental health services since the closest institution assistance is in many places more than 200 miles away. The result all too often is that consultation is avoided until the problem becomes so critical that institutionalization is required.

The Prairie View center in south-central Kansas also stands in dire need of staffing funds and a new community health center in eastern Kansas will not receive the $215,000 needed to meet startup costs unless the program's authority is extended. The 1-year extension of the Community Mental Health Center Authority is important in Kansas, because the mental health activities in the State are now at a critical stage. Federal assistance at this time is needed to put the program on its feet, so it can stand alone in the future.

STUDENT ASSISTANCE

Other legislative authority extended 1 year by S. 1136 are the Allied Health Professions Personnel Act, which provides scholarships, grants, work-study programs, and loans for allied health students. These provisions are important to Kansas since approximately one-half of health professions students depend on some type of assistance.

S. 1136 will also extend the authorization for the Partnerships for Health Act which provides 314 (a), (b), and (d) funds for State and areawide health planning agencies and the formula grants for public health services programs. The Developmental Disability Services and Facilities Construction Act is extended for 1 year and will continue the demonstration and training grants for the university affiliated facility program operated at the UAF centers in Parsons, Lawrence, and Kansas City.

These public health service and mental health programs are of particular significance in Kansas, although their record nationwide may not be as strong as we might hope. Cessation of Federal support for these programs at this time and on such short notice would be a blow to the health care in Kansas and a waste of the funds already invested in many of these programs up to this time.

Mr. MONDALE. Mr. President, it is essential that the Congress act promptly to extend these important health authorities which would expire on June 30. This is important not only to the institutions and beneficiaries who depend on these programs, but it is a test of the role of the Congress itself. I do not overstate the case when I say that the issue of the constitutional separation of powers is at stake here.

The administration has proposed in its 1974 budget that four of the programs which would be extended by this bill be terminated in the next fiscal year. However, we have not had the benefit of any detailed analyses or recommendations on those or any other of the programs which expire. Instructions have already gone out to recipients of funds under some programs looking toward their termination, without any consideration by the Congress.

A very novel and radical theory of the power of the executive branch has been put forth by the administration this year. As we all know, the administration is attempting to phase out the Office of Economic Opportunity and some of its programs—notwithstanding the fact that only last year the President signed a bill extending the programs for 2 years. Termination actions are underway at this very moment, based simply on the President's proposal—and I underscore proposal—that funds be withdrawn from community action programs next year. Here is a case where the statutory authority for continuing the OEO programs is clear—and yet the administration asserts the right to terminate them merely because it has not proposed funds for them next year.

In light of this dangerous precedent, it is quite clear that the administration's intent is to prevent the Congress from expressing its will concerning such vital programs as the Hill-Burton hospital program, the regional medical program, the community mental health centers program, allied health training, and public health training. It simply proposes to end them—without waiting for concurrence of the Congress. I wonder what has happened to the time-honored tradition that "the President proposes and the Congress disposes." I wonder what has happened to the constitutional provision that legislative powers are vested in the Congress. I wonder what has happened to the Constitution's charge that the President "take care that the laws be faithfully executed."

We do not stubbornly insist on the simple continuation of programs about which the administration has serious objections. We have repeatedly asked the executive branch for its specific recommendations and for its detailed analyses. They have not been forthcoming. Indeed, last May, the Secretary of Health, Education, and Welfare declined our invitation to testify on these very matters. He promised that the recommendations of the administration would be developed in plenty of time for the Congress to consider them before the authorities expired in June 1973. They have never been received.

Assistant Secretary of Health, Education, and Welfare Duval testified in July 1972, that the detailed recommendations of the administration should be expected "in connection with the 1974 budget." That budget was received 2 months ago and the legislative recommendations still have not been received.

In January 1973, Mr. Caspar Weinberger told the committee that the administration's detailed legislative recommendations should be expected in February or March. However, just last week, Secretary Weinberger testified that the administration still was not prepared to submit its detailed legislative recommendations and urged that the committee not act on extension of these expiring authorities.

Although he told us that he believed "it would be in everyone's interest to face the issues now," he is still not prepared to tell us what the specific recommendations of the administration are. In these circumstances, I think it would be a serious abdication of the constitutional role of the Congress to permit the administration arbitrarily and unilaterally to terminate these programs which have long served so well to help in improving the health of our citizens.

We are entirely prepared to consider revisions and consolidations of these programs, where the case can be made. But it is incumbent upon the administration to present its proposals to us and let us consider how to deal with them. For example, many have pointed out that the regional medical program has in some cases not achieved its objectives and and it overlaps other programs. Perhaps some of these programs have not been successful. But we have in Minnesota the northlands regional medical program which is one of the most outstanding health programs in the Nation. It should not be abolished, because other programs have been unsuccessful. As far as duplication is concerned, my colleagues and I are fully prepared to consider how to relate this program better to others which the administration proposes to continue. Similarly, many criticisms have been leveled at the Hill-Burton hospital construction program—alleging that we now have a surplus of hospital beds and that we need no more new construction assistance. But the administration has failed to tell the Congress and the public how this argument relates to the proposed termination of authority for modernization of hospitals.

We have many hospitals throughout the country, especially in large cities, where the plants are so obsolete that costs are enormously high and care is not as good as it should be. In Minneapolis for example, we have begun to replace obsolete facilities of the Metropolitan Medical Center and Hennepin County General Hospital. This is a very innovative program which provides for joint use by a public and private hospital of certain facilities. It has been widely praised as an example of the best kind of planning which we should demand in our hospital programs. We do not propose to add any hospital beds at all through this project. In fact, it contemplates a reduction in the number of hospital beds.

No one wishes to build additional hospital beds where they are unnecessary and we have effective State planning mechanisms to assure that we do not. But it is absolutely vital that we continue to replace obsolete plants with the most modern facilities that we can design and build. This clearly cannot be done without continued Federal assistance.

The same thing applies to the other programs the administration wants to terminate. Where a case can be made for revision, we will be glad to consider it. But we cannot permit the executive branch to terminate these programs unilaterally—and without any assurance that an adequate substitute will be available.

Another example is the community mental health centers program. Here, the administration argues that the program has been successful—so it should be terminated. The rationale for terminating the community mental health centers program is nothing more than that, eventually, we will have a national health insurance program which will permit everyone to purchase needed mental health services. However, we have yet to receive the administration's health insurance proposals. Two years ago, the President made recommendations for national health insurance, but it was many months until the bills finally reached the Congress. When they did, and we examined them, we discovered that 38 million people were left completely outside of the coverage of its proposals. Certainly, with this kind of background, we cannot permit a valuable program to be terminated merely on the promise that someday we will have new legislative recommendations which will fill the gap.

Mr. President, I cannot believe that the Congress is ready to close its doors and turn over all of the powers of Government to the President of the United States. We were elected to legislate—and legislate we must. This bill is an essential step in carrying out our constitutional responsibilities. I hope that it will be approved by an overwhelming margin in the Senate and speedily acted on by the House.

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Mr. PEARSON. Mr. President, I rise in support of legislation extending for 1 year at present funding levels 10 major health programs which would normally expire at the end of the current fiscal year. In my judgment, passage of this bill is needed to insure a continuing Federal commitment to the goal of helping provide quality health care to all Americans.

We now find ourselves in a pressing situation, both with regard to the continued vitality of Federal health programs and the proper relationship between the executive and legislative branches. Last year, the Senate approved with my support legislation extending the Public Health Service Act and the Community Mental Health Centers Act in a manner similar to the bill now before us. Although the lateness of Senate approval precluded House action prior to adjournment, there was a clear indication of congressional support for the programs covered by these two acts.

At that time, we were assured by the distinguished chairman of the Senate Health Subcommittee that a thorough review and recodification of existing health programs were underway, an effort which would include an extensive study of their goals, their accomplishments, and the feelings of the American people toward them. Although this review continues on a priority basis, the situation has been further complicated by the administration's abandonment of major health programs in the proposed fiscal year 1974 budget.

Mr. President, the duty of Congress in this instance is clear. In my judgment, decisions which the President has made regarding the Nation's health program are not his to make alone. Administration statements to the contrary, there are several programs which have achieved not only substantial results, but the solid support of the communities they serve as well.

Among these is the Kansas regional medical program which in 1967 became one of the first such programs in the country to receive Federal funding under an expanded Public Health Service Act. The KRMP represents a consortium of local medical providers designed to respond to the particular health needs of Kansas. Altogether this program coordinates the operations of 26 separate activities, ranging from emergency treatment programs to the upgrading of health care facilities in rural, sparsely populated regions of the State.

The efforts of KRMP to improve the health system in Kansas have yielded substantial results. In conjunction with the Kansas University Medical Center, KRMP has trained nearly 1,500 emergency medical services personnel, including the Kansas Highway Patrol. Together with numerous State officials, KRMP is now involved in the development of a statewide emergency medical services master plan.

In rural Ottawa County, heretofore lacking in primary health care facilities, the KRMP established a clinical health care system in cooperation with local physicians. This program was so well received that county citizens have voted to increase public expenditures for its continuation, no small achievement in light of growing public opposition to rising taxes.

Mr. President, these are but two of the many fine examples which amply demonstrate the efficacy of this program and its value to Kansas. But unless the legislation now before us is enacted, there will be no further Federal support after June of this year.

It would indeed be unfortunate if the Federal Government discontinued its funding of this worthy effort. For this is not just another bureaucracy operating by long distance from Washington. Rather, it is a federally financed, local effort which has received the endorsement and cooperation of State officers, local governments, and—most importantly—the people of Kansas.

As an example of how all levels of Government can meet the needs of the Nation, this and other health programs now scheduled for extinction deserve continued Federal support. As an indication of the continuing national effort to respond to health needs, the bill we now consider deserves congressional support.

Mr. President, I ask unanimous consent that three editorials from Kansas newspapers be inserted in the RECORD at this point. Those from the Kansas City Kansan and the Great Bend Daily Tribune describe further the activities of the KRMP. The editorial from the Phillipsburg Review outlines programs which the KRMP and the Kansas State Legislature have formulated.

There being no objection, the editorials were ordered to be printed in the RECORD, as follows:

[From the Kansas City Kansan, July 28, 1971]

HEALTH CARE QUALITY GOOD

Quality of health care available to Kansans is higher today than at anytime in the past.

This continuous upgrading of care is due to efforts of many individuals, institutions and organizations. However, much credit is due to projects conducted during the past four years by the Kansas Regional Medical Program.

KRMP is a federally funded, locally controlled effort to upgrade health care thruout the state. Headquartered at the University of Kansas Medical Center, KRMP has sponsored a variety of training programs since its founding designed to familiarize health professionals in the state with latest techniques of treatment.

It has proved most useful in spreading new medical developments from the confines of the reesarch lab to the practicing physicians, nurses and other health professionals in small towns and hospitals thruout Kansas.

The regional medical program was founded here in 1966 as part of a national effort to more effectively combat heart disease, cancer and stroke. It began operations in 1967 under a federal grant of slightly more than $1 million.

Since then, KRMP has sponsored training courses for occupational and physical therapists, circuit courses to upgrade the training of practicing nurses, seminars for doctors in the use of drugs to treat cancer, coronary care programs for nurses and a host of other projects designed to help health professionals help their patients.

The program recently received a federal grant for about $1,762,000 to finance its fifth year in operation which will include three major new projects as well as continued operation of five existing projects.

One of the new projects will be to train 40 nurses for expanded roles as nurse clinicians who will perform many routine tasks that now take up much of physicians' time. These nurses will take an 8-week primary academic course at KUMC and then train for 10 months under the doctors for whom they will work. Such use of nurses is one answer to the doctor shortage. Ivan Anderson, KRMP associate director, said the program may improve the productivity of physicians by as much as 25 to 30 per cent.

Another program is designed to train kidney patients and their families to perform home dialysis, a process by which the patients' blood is "washed" of impurities by machine, a function normally performed by the kidneys.

This program will also train nurses thruout the state in the care of kidney patients.

The third new program will establish a tumor registry. It will contain a central file on cancer cases in the state, thereby helping identify the nature and prevalence of cancer in Kansas. The registry will also forward to individual doctors the recorded experiences of other physicians on the best methods of treating certain types of cancer.

KRMP's five continuing programs include a 6-week refresher course for inactive nurses in Kansas City, Kan., a cardiac care education course in Wichita, a year-round area educational program for doctors, nurses and other health professionals in Great Bend, training for medical records clerks and a network of medical libraries with call-in service available to physicians thruout the state.

Altho these programs are designed to train health professionals, the real beneficiaries will continue to be the people of Kansas.

[From the Great Bend Daily Tribune, Oct. 25, 1971]

BENEFIT TO ALL

The Kansas Regional Medical Program, in which the Central Kansas Medical Center is involved, has recently issued its fourth year report.

It has a set of goals which are designed to continually up-grade the health services which are provided by members of the medical profession. With the University of Kansas Medical Center as the base, the KRMP includes a number of hospitals in its program.

A glance at the report indicates some of the achievements of the regional program. A medical library network for Kansas with staff in Kansas City, Great Bend, Topeka and Wichita is established; courses have been held for dieticians; special programs have been held for nurses who deal with patients with kidney problems, strokes and heart disease; training programs have reactivated 65 inactive nurses from 14 counties. These are but a few of the wide range of the health spectrum in which the Kansas Regional Medical program has been operating during its past four years.

Obviously, its efforts have been of great benefit to everyone in this area of the state in particular through the association of the Central Kansas Medical Center with the program. It should be a matter of state pride that Kansas was one of the first states to receive federal support for such a program . . . and that this area's medical center should be the first to be included in the state program.

[From the Kansas Phillipsburg Review, Feb. 22, 1973]

HEALTH CARE DELIVERY

A year ago Kansas broke new ground in an effort to improve the delivery of general health care throughout the state when the

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legislature made a minor and little noticed change in the statutes which permitted the K. U. Medical Center to support medical residences away from the walls of the University hospital.

Kansas thus became the first state to recognize the value of a broader medical experience for young doctors, who can now receive a portion of their medical education in general hospitals of high quality located in situations which deal with the health problems of the public on a day-to-day basis.

Yet quality control was not surrendered. This learning experience is still under the direction and control of the K. U. Medical Center, which must approve the hospitals, and the staff involved before setting up a residency program, and the work is under constant review.

The direct action taken here conforms to the new emphasis on the Family Practice specialty, which equips young doctors to meet general health care needs, contrasted to the more sophisticated specialties in which complete concentration on one single phase of medicine is given throughout the period of residency.

Medical authorities have been recognizing the need for far more emphasis on family practice than has been given by medical schools in the past 15 years.

Dr. David E. Rogers, Dean of the Medical School at Johns Hopkins University, summed up the change in thinking in a recent statement to the American Medical college:

"We must stop pretending that we are adequately fulfilling our educational mission by continuing to limit our faculty, our students and efforts almost exclusively to this one special institution (the University hospital) . . . Our obligation to the training of physicians that we must have multifaceted educational laboratories that will permit the student to become acquainted in health problems as they are encountered by members of a community . . . not just those which are important to a research-oriented faculty."

Kansas has now taken the first steps in this direction.

Dr. Wm. O. Rieke, vice chancellor for health affairs at the K. U. Medical Center, feels that the extension of the medical center program into well-equipped hospitals with competent personnel, is a desirable objective to give residents more exposure to general health needs at the community level; but at the same time, that this extension must be under the supervision and control of the medical center.

A program of this type is already under way. Dr. Jack Walker, at the same time, is heading up a new department of Family Practice Specialty at the Medical Center. Wesley Hospital, at Wichita, which started such a program under the direction of Dr. Stan Mosier and Dr. Vic Voorhees, already has 17 young graduate doctors taking a three-year family practice course.

In the past, fully 80 percent of all young doctors have entered the more sophisticated specialties, learning virtually everything about one phase of medicine and very little about others. General health care needs, however, comprise fully 80 percent of the work of the medical profession, and new emphasis is now being placed on this latter phase of public need in Kansas.

During this same period, new attention has been centered on paramedical assistance with special course work now offered under K. U. Medical Center auspices at Wichita University for nurse-clinicians under the direction of Dr. Cramer Reed.

Registered nurses may take this concentrated course of instruction, and then be certified to do such tasks as may be assigned to them by the primary physician. It is emphasized that no patient may be treated, however, without the instructions of the physician.

The Hansen Health Care program proposes to use these new skills with a central radioband network. The procedures have been checked at all levels of the medical profession.

Dr. Bob Brown, director of the Kansas Regional Medical Advisory Council, who is working on other innovative programs for the development of Rural Health Care, says the program is headed "in the right direction."

The Hansen Foundation, in establishing a grant to finance the "D. G. Hansen Rural Health Care Program" is putting all of these innovative steps together in a single "package." It is the hope of the Foundation that a pilot project which will be of assistance in developing better rural health care everywhere, has here been started.

We hope so, too, for better health care is the most vital and pressing need of countless communities across the land, and we hope that what helps us may help others.

THE EFFECTS OF PRESIDENT NIXON'S POLICY TO TERMINATE COMMUNITY MENTAL HEALTH CENTERS PROGRAM ON INDIANA

Mr. BAYH. Mr. President, I speak in support of the Public Health Services Assistance Extension Act of 1973, of which I am a cosponsor and urge its passage.

S. 1136 now under consideration has one purpose: to reaffirm the intention of Congress that Congress will determine whether and which of the health programs extended for 1 year by the bill will continue. Executive budget action which lets certain health programs wither, vanish, or be effectively terminated by lack of adequate funding, is not the appropriate mechanism to determine the fate of vital substantive health programs affecting millions of Americans.

We have known for some time that the expiration of the major portions of the Public Health Service Act would create a legislative logjam. We attempted to anticipate that last year, and in fact successfully passed S. 3716 by a 78 to 0 vote, to improve many of the expiring provisions. The administration testified in opposition to that and it died in the House. Despite repeated attempts to get constructive legislative proposals from the administration, and despite repeated assurance that such legislation would be forthcoming—first by January, then by February, then before spring—none has been forthcoming.

Many of the affected health programs were passed in some of the finest hours of the Congress, and with the full and active support of past Presidents. But now we are confronted with a President who would turn away from the good we have accomplished, who would withdraw the gains we have made, and who would say to the American people regarding these vital health programs: "You'll get no more assistance from the Federal Government. From now on you can work things out for yourself."

The President's budget for fiscal year 1974 proposes the total elimination on radical restructuring of the Hill-Burton hospital program, the allied health training program, the regional medical program for heart, cancer, and stroke, the public health training program, and the community mental health centers program.

Our bill makes no substantive changes in the law. It simply extends the life of the following health programs from June 30, 1973, to June 30, 1974: Health services research and development, health statistics, public health training, migrant health, comprehensive health planning, Hill-Burton, allied health training, regional medical programs, medical libraries, and community mental health centers.

The impact of the President's health budget proposals is graphically illustrated in the case of the community mental health centers programs.

A decade ago, the Congress passed the Community Mental Health Center Act, which was designed to establish 2,000 centers throughout the Nation. The goal of these centers has been to make high quality care available to all citizens who suffer from the many mental illnesses. In addition, they provide special programs for the mental health of children, for drug abuse, and for alcoholism.

Today, 515 community mental health centers have been established. That is scarcely one-fourth of the total required to reach all Americans in the local community setting. Already the centers have been proven successful, and have relieved the overcrowding and stress that exists in too many State mental hospitals.

Does President Nixon want to expand this humane legislation? He does not. His budget proposes that the legislation be allowed to expire this June 30—with nearly 1,500 centers remaining to be built and staffed.

The Office of Management and Budget has come up with an ingenious device for obscuring the administration's real intentions. At first glance, the fiscal 1974 request for mental health programs appears to be doubled.

But the total includes $636 million that would not be spent in 1974 at all. That amount, already authorized for the centers, would be portioned out annually through 1980. President Nixon would end Federal support in 1980, and the centers would have to rely entirely on State and local governments, private contributors, and third-party payment systems.

And not only Federal taxes are supporting these centers today. Federal funds currently amount to only about 30 percent of the centers' total budget. State and local governments already provide 40 percent of the funds needed to keep the centers at their important work. The Federal contribution is needed, and will be needed beyond 1980, to establish new centers and to assist those already in operation.

The effects of this action on community mental health in Indiana will be serious.

Currently there are 8 federally funded centers in Indiana, 4 of them serving areas designated as urban or rural poverty areas. These centers provide comprehensive mental health services to a total population of 1,398,242 people making these services readily available within their own community. Emphasis is placed on ambulatory care, to encourage the patient to continue living at home if possible or in small community residential centers.

A fully comprehensive range of services

is required of all federally funded centers to insure that every patient receives the form of care best suited to his needs. Federally funded centers provide a unique system of care for all persons in a designated area, including preventive services—provided through education and consultation programs for schools, probation and police departments, welfare agencies, church groups and other public agencies. Linkages with other caregivers in the community, required under the Federal program, insure continuity of care, as well as early detection of mental disorders or potentially handicapping conditions.

Care in a community mental health center is demonstrably more effective and less costly than institutional care. Yet, under the Nixon administration's policy it is highly probable that over the next several years many people in Indiana will be denied community care—and referred instead to State mental hospitals—because alternative care will just not be available.

To give some idea of the Federal contribution to Indiana through the CMHC program, grants totaling $2.728 million were awarded to Indiana centers in fiscal year 1972, and $3.038 million in fiscal year 1973. These grants break down as follows:

To meet part of the costs of staffing:	
Fiscal year 1972	$2,303,000
Fiscal year 1973	2,670,000
To meet part of the costs of staffing a specialized facility for children:	
Fiscal year 1972	425,000
Fiscal year 1973	368,000

Under current law each Federal grant is reduced gradually over an 8-year period. As these grants drop off—and under the administration's current policy, as they expire completely—local communities and the State of Indiana must pick up approximately $3 million per year. This is in addition to the contribution already made by the State and localities to meet the costs of the CMHC program which are not covered by the Federal grant. These include all operational costs, as well as the non-Federal share of staffing costs. The most immediate and direct effect on Indiana of Mr. Nixon's policy would, however, be the loss of $1,087,786 in Federal funds which were to have been awarded shortly.

There are a total of 33 catchment areas in Indiana, yet only eight of these areas have a community mental health center. The termination of the Federal program makes it highly unlikely that the remaining 25 catchment areas will be served by a CMHC at any time in the near future. The large reductions in Federal categorical grant programs, as well as the impact of the termination of the centers' program itself, will place a heavy burden on the State's resources. While existing centers may be able to recover lost Federal dollars from the State, it seems highly questionable whether new centers, which require a considerable investment, will be initiated.

In two of these catchment areas, planning for a comprehensive community mental health program has been completed, and applications for Federal grants approved by NIMH. As a direct result of the cutoff in new grants awarded—which the administration ordered in fiscal year 1973—these two centers will not receive more than $1 million which they had expected. In addition, the Mental Health Center of St. Joseph County, which received a Federal construction grant in 1968, will not receive its expected staffing grant. This center's grant application has also been aproved by NIMH and would have been awarded had funds been available. Whether the center can continue to offer services to its community under these circumstances is questionable.

Thus Indiana will not receive the following CMHC program funds, although the grants have been approved:

Mental Health Center of St. Joseph County, South Bend, Ind., $265,212.

Region Ten Community MHC, Columbus, Ind., $557,362.

Regional MHC, Kokomo, Ind., $266,212.

If these services—already expected in the communities—are to be provided, State and local tax money must meet the entire costs, including the $1.1-million share the Federal Government was expected to provide.

Perhaps the most tragic aspect of the administration's policy is that we are ending the Federal effort with less than one-quarter of the centers needed to service the entire country. Slow as our progress has been, there has until now been a growth in the number of centers operating every year since 1966. Unfortunately, that growth seems likely to end. Of the 33 catchment areas in Indiana nine are in poverty areas—areas where alternative sources of funds are extremely scarce. For those living in the 25 areas not serviced by a community mental health center and in need of care the outlook is now grim. Many will wind up in the State mental hospital, becoming an even greater burden to the taxpayer.

Others will continue to live in the community while their condition steadily worsens, requiring, eventually, more expensive treatment and having less chance of a complete recovery.

Ironically this administration has stressed its support for the concept of community mental health, and the question of whether the federally funded community mental health centers program has provided better and more readily accessible care is not at issue. For example, in the HEW budget the termination of the CMHC program is justified as follows:

> The workability of the community mental health center concept has been thoroughly demonstrated and a large portion of a national system will have been put into place when the eight year grants provided for in current law are concluded. The Administration proposes that the Community Mental Health Centers Act be allowed to expire on June 30, 1973 on the grounds that the current momentum behind the community mental health center concept should be adequate to maintain existing centers and stimulate the establishment of new centers.

On another occasion, an administration aide recently assessed the community mental health centers program success and concluded that the Federal program was "inequitable, because people served by the federally funded centers receive better care than the rest of the Nation."

Last week Mr. Caspar W. Weinberger, Secretary of Health, Education, and Welfare reiterated the administration's curious attitude toward the mental health centers program, in testimony before the Senate Subcommittee on Health. Mr. Weinberger said in part:

> We believe that continued preferential treatment by the Federal Government of a few communities is unwarranted.

This is indeed a curious position for an administration that is determined to see to it that less than one-fourth of the centers contemplated by Congress when it passed the act will even get off the ground. Of course the obvious way to guarantee that each community in need of such a center has the opportunity to develop one is to extend the program and fulfill the mandate of Congress.

Thus the question is not "Do we continue to fund community mental centers?" the question is "How do we provide the funding?"

The administration maintains that States and localities together with contributions by public and private health insurance plans can support community mental health centers. Yet, most insurance plans do not cover the services offered in mental health centers and a bare 12 percent of all centers' income is derived from public and private health insurance. Furthermore, the administration's own Health Insurance Partnership Act of 1972 did not even provide coverage of mental health services, and its 1973 proposal is not expected to remedy this. Should some form of Federal health insurance program be enacted which does provide full coverage for CMHC services, the administration has still failed to explain how centers are to survive in the meantime.

The States and localities it seems, under the administration's policy, must pick up the tab. As of this date, Indiana will have received a total of $4.92 million under this program.

The following chart indicates the population being served by federally funded community mental health centers in Indiana. P indicates a center serving a designated poverty area:

	Population served
The Community MHC (P)* Indianapolis, Ind	197,070
Southern Indiana-MH & Guidance Ctr., Inc. (P)* Jeffersonville, Ind.	200,000
Comp. CMHC (P)* Vincennes, Ind.	75,490
Southwestern Indiana MHC, Inc.,* Evansville, Inc	248,000
Katherin Hamilton MHC, Inc. (P)*, Terre Haute, Inc	216,637
Mental Health Center of St. Joseph Co., Inc., South Bend, Ind.	124,723
Memorial Hosp. of South Bend, South Bend, Ind	120,322
Community Hospital of Indianapolis, Inc., Indianapolis, Ind	216,000
Total	1,398,242

* Operational (other centers have received construction funds only).

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It seems incredible that so worthy a program would be dropped. But most incredible of all is the administration's twisted reasoning for phasing out support of community mental health centers. People receive better care at these centers. That is why they were established. That is why they should be strengthened, not weakened, and that is why more centers are needed.

Mr. President, the importance of this particular measure is not any one or more of these health programs, but the total constitutional issue of how our laws are to be made.

It is entirely appropriate for the President to urge Congress to terminate any one or more of these existing health programs and provide the evidence to Congress to justify his recommendation. But the action of the executive must be checked and balanced by the Congress, that is the genius of the American political system.

I am not totally satisfied with each and every one of the programs that will be extended by S. 1136, but the passage of this bill will provide the necessary time frame for Congress to work its will regarding all of the provisions and to bar an executive budget recommendation from determining either what health programs are to live or die, or how these programs are to be modified, improved, and implemented.

YEAR EXTENSION OF HEALTH PROGRAMS ESSENTIAL, SAYS SENATOR RANDOLPH

Mr. RANDOLPH. Mr. President, I support the measure now being considered in the Senate to extend the expiring authorities of the Public Health Service Act, the Community Mental Health Centers Act, and the Developmental Disabilities Services and Facilities Construction Act. I commend the capable chairman of the Subcommittee on Health (Mr. KENNEDY) for his leadership in bringing S. 1136 to the Senate.

Some 12 major health programs will expire on June 30 of this year unless the pending measure, S. 1136, is enacted into law. The President's budget for fiscal year 1974 indicates the administration's intention to allow many of these to expire. With respect to others, no specific legislative recommendations have been forthcoming.

It is my strong belief that a 1-year extension of these expiring authorities is absolutely necessary. The administration only 2 months ago revealed some of its intentions with respect to expiring health programs. If we, in the Congress, are to legislate intelligently we must carefully review the administration's rationale for terminating or revising these programs. We, in the legislative branch, of the Federal Government must make our own assessment of what should be terminated or consolidated or revamped. The short period of time between now and June 30 will not permit the careful scrutiny of these complex health programs that will be required if Congress is to act responsibly.

The able Senator from Massachusetts has outlined the meaning of S. 1136. I wish to focus specific attention on just three of the programs proposed to be extended.

DEVELOPMENTAL DISABILITIES ACT

The Developmental Disabilities Services and Facilities Construction Act became law in 1970. Its authorizations expire this June, as do those of the other programs in S. 1136. Hearings have been held by the Subcommittee on the Handicapped, which I am privileged to chair, on S. 427, a bill to extend the act for 1 year.

Although the subcommittee intended to review carefully the operation of the Developmental Disabilities Act with the hope that whatever substantive changes were necessary could be made before the end of the fiscal year, it soon became apparent that a great number of concerns have arisen with respect to the operation of that act. These concerns have centered on the methods by which funds are being allocated, how funds are being spent, and how the law has been implemented and administered.

In order to fulfill our responsibility of legislative oversight, the Subcommittee on the Handicapped has initiated an in-depth study of the developmental disabilities program. We have asked the General Accounting Office to provide in detail answers to a rather lengthy list of questions. An adequate GAO response will take time, more time than is remaining in this fiscal year. When the General Accounting Office completes its report, it is my firm intention, and that of the members of the Subcommittee on the Handicapped, to review the report and develop substantive legislation without delay.

The Committee on Labor and Public Welfare, in order to prevent the expiration of the Developmental Disabilities Act, and to provide adequate time for a detailed study of that act, agreed to include a 1-year extension of the act under the aegis of S. 1136.

HILL-BURTON PROGRAM

The administration is seeking to end the very successful, 27-year-old Hill-Burton hospital construction program. The justification for the administration's position was provided by the Secretary of Health, Education, and Welfare in testimony before the Committee on Labor and Public Welfare on March 22, 1973. The Secretary stated:

> We have clearly passed the point where this kind of special Federal intervention is needed by our health service delivery system. . . . A special Federal grant program for hospital construction is now unwarranted.

I indicated to the Secretary my belief that although the total number of hospital beds in the United States may be adequate on paper, there is a maldistribution of such facilities. I also expressed the belief that the Hill-Burton program had a definite continuing function with respect to the renovation of old hospital facilities and providing new outpatient care facilities.

Certainly the Hill-Burton program is neither outmoded nor unnecessary in my own State of West Virginia. In fact, if there were no limitations on Federal matching grant funds, West Virginia could initiate worthwhile, necessary projects totaling $88.8 million over the next 2 years. In fiscal year 1974, my State also could utilize over $36.6 million in Hill-Burton funds. I am certain that other States are similarly situated. The administration's pronouncements notwithstanding, the Hill-Burton program is most definitely not passé.

REGIONAL MEDICAL PROGRAM

Another program that the administration seeks to terminate is the regional medical program. It appears that the principal argument for discontinuation is that RMP has mainly operated as a source of continuing education for professionals generally capable of financing their own education. This is not at all my understanding of the function or operation of the program in West Virginia. In my State, seven clinics are being built in remote rural areas where medical service has heretofore been virtually nonexistent. The State RMP has developed a pediatric nurse assocate program to expand the medical resources available to children. Valued assistance has been provided by the West Virginia RMP in obtaining grants for various health programs in the State.

The Secretary of HEW also stated in his testimony of March 22:

> We are proposing the termination of the Regional Medical Program because we believe that it has not achieved its promise when it was first enacted seven years ago, and shows no reasonable chance of doing so in the future.

During its short life the West Virginia regional medical program has undertaken no fewer than 38 projects, including a rural multicounty emergency medical service program, home health care, maternity care using nurse midwives, a biomedical computer information project, surveys of health needs, and many others. Without the RMP, I fear that many of these badly needed projects would not be carried forward in West Virginia.

Mr. President, I conclude by reaffirming my strong support for the enactment of S. 1136, and I urge my colleagues to favor the continuation of these vital health programs with their affirmative votes.

The PRESIDING OFFICER. The bill having been read the third time, the question is, Shall it pass? On this question the yeas and nays have been ordered, and the clerk will call the roll.

The second assistant legislative clerk called the roll.

Mr. COTTON. Mr. President, on this vote I have a pair with the distinguished Senator from South Carolina (Mr. THURMOND). If he were present and voting, he would vote "yea." If I were permitted to vote, I would vote "nay." I withhold my vote.

Mr. ROBERT C. BYRD. I announce that the Senator from Louisiana (Mr. JOHNSTON), the Senator from Maine (Mr. MUSKIE), the Senator from California (Mr. TUNNEY), the Senator from New Jersey (Mr. WILLIAMS), are necessarily absent.

I also announce that the Senator from Mississippi (Mr. STENNIS) is absent because of illness.

I further announce that, if present and voting, the Senator from New Jersey (Mr. WILLIAMS), the Senator from Louisiana

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(Mr. JOHNSTON), the Senator from California (Mr. TUNNEY) would each vote "yea."

Mr. GRIFFIN. I announce that the Senator from Massachusetts (Mr. BROOKE) is absent by leave of the Senate on official business.

The Senator from Wyoming (Mr. HANSEN) and the Senator from South Carolina (Mr. THURMOND) are necessarily absent.

The pair of the Senator from South Carolina (Mr. THURMOND) has been previously announced.

The result was announced—yeas 72, nays 19, as follows:

[No. 66 Leg.]

YEAS—72

Abourezk	Ervin	McIntyre
Aiken	Fong	Metcalf
Allen	Fulbright	Mondale
Baker	Gravel	Montoya
Bayh	Gurney	Moss
Beall	Hart	Nelson
Bellmon	Hartke	Nunn
Bentsen	Haskell	Packwood
Bible	Hatfield	Pastore
Biden	Hathaway	Pearson
Burdick	Hollings	Pell
Byrd, Harry F., Jr.	Huddleston	Percy
Byrd, Robert C.	Hughes	Randolph
Cannon	Humphrey	Ribicoff
Case	Inouye	Saxbe
Chiles	Jackson	Schweiker
Church	Javits	Sparkman
Clark	Kennedy	Stafford
Cook	Long	Stevenson
Cranston	Magnuson	Symington
Dole	Mansfield	Talmadge
Dominick	Mathias	Weicker
Eagleton	McClellan	Young
Eastland	McGee	
	McGovern	

NAYS—19

Bartlett	Goldwater	Scott, Pa.
Bennett	Griffin	Scott, Va.
Brock	Helms	Stevens
Buckley	Hruska	Taft
Curtis	McClure	Tower
Domenici	Proxmire	
Fannin	Roth	

PRESENT AND GIVING A LIVE PAIR, AS PREVIOUSLY RECORDED—1

Cotton, against.

NOT VOTING—8

Brooke	Muskie	Tunney
Hansen	Stennis	Williams
Johnston	Thurmond	

So the bill (S. 1136) was passed, as follows:

S. 1136

An act to extend the expiring authorities in the Public Health Service Act and the Community Mental Health Centers Act

Be it enacted by the Senate and House of Representatives of the United States of America in Congress Assembled That this Act shall be known as the "Public Health Service Act Extension of 1973".

SEC. 2. (a) Section 304(c)(1) of the Public Health Service Act (42 U.S.C. 201) is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(b) Section 305(d) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(c) Section 306(a) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(d) Section 309(a) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(e) Section 309(c) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(f) Section 310 of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(g) Section 314(a)(1) of such Act is amended (1) by striking "June 30, 1973" the first time it appears and inserting in lieu thereof "June 30, 1974", and (2) by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(h) Section 314(b)(1)(A) of such Act is amended by—

(1) striking the term "June 30, 1973" in the first sentence and inserting in lieu thereof the term "June 30, 1974"; and

(2) striking the phrase "for the fiscal year ending June 30, 1973" in the second sentence and inserting in lieu thereof "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(i) Section 314(c) of such Act is amended by—

(1) striking the term "June 30, 1973" in the first sentence and inserting in lieu thereof "June 30, 1974"; and

(2) striking the phrase "for the fiscal year ending June 30, 1973" in the second sentence and inserting in lieu thereof "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(j) Section 314(d)(1) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(k) Section 314(e) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(l) Section 393(h) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(m) Section 394(a) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(n) Section 395(a) of such Act is amended by striking "June 30, 1973" and inserting in lieu thereof "June 30, 1974".

(o) Section 395(b) of such Act is amended by striking "June 30, 1973" and inserting in lieu thereof "June 30, 1974".

(p) Section 396(a) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(q) Section 397(a) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(r) Section 398(a) of such Act is amended by striking "June 30, 1973" and inserting in lieu thereof "June 30, 1974".

(s) Section 601(a) of such Act is amended by striking the word "eight" and inserting in lieu thereof the word "nine".

(t) Section 601(b) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(u) Section 601(c) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(v) Section 621(a) of such Act is amended by striking "June 30, 1973" wherever it appears and inserting in lieu thereof "June 30, 1974".

(w) Section 625(2) is amended by striking out "for the fiscal year ending June 30, 1973" and inserting in lieu thereof "for each of the fiscal years ending June 30, 1973, and June 30, 1974".

(x) Section 631 of such Act is amended by striking the word "two" and inserting in lieu thereof the word "three".

(y) Section 791(a)(1) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(z)(1) Section 792(a)(1) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(2) Section 792(a)(2) of such Act is amended by striking "June 30, 1973" and inserting in lieu thereof "June 30, 1974".

(aa) Section 792(b) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(bb) Section 792(c)(1) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(cc) Section 793(a) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(dd) Section 794A(b) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(ee) Section 794B(f) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(ff) Section 794C(e) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(gg)(1) Section 794D(c) is amended (A) by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof "for each of the fiscal years ending June 30, 1973 and June 30, 1974", (B) by striking out "each of the two succeeding fiscal years" and inserting in lieu thereof "each of the three succeeding fiscal years", and (C) by striking out "July 1, 1973" and inserting in lieu thereof "July 1, 1974".

(2) Section 794D(e) is amended by striking out "1977" each place it occurs and inserting in lieu thereof "1978".

(3) Section 794D(f)(1)(A) is amended by striking out "each of the next two fiscal years" and inserting in lieu thereof "each of the next three fiscal years".

(hh) Section 901(a) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(ii) Sections 1001(c), 1002(d), 1003(b), 1004(b), and 1005(b) of the Public Health Service Act are amended by striking out "for the fiscal year ending June 30, 1973" and inserting in lieu thereof "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

SEC. 3. (a) Section 201 of the Community Mental Health Centers Act (42 U.S.C. 2681) is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(b) Section 207 is amended by striking out "1973" and inserting in lieu thereof "1974".

(c) Section 221(b) is amended by striking out "1973" each place it occurs and inserting in lieu thereof "1974".

(d) Section 224(a) of such Act is amended (1) by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974" and (2) by striking out "thirteen succeeding years" and inserting in lieu thereof "fourteen succeeding years."

(e) Section 246 of such Act is amended by striking "June 30, 1973" and inserting in lieu thereof "June 30, 1974."

(f) Section 247(d) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974."

(g) Section 252 of such Act is amended by striking "June 30, 1973" and inserting in lieu thereof "June 30, 1974".

(h) Section 253(d) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(i) Section 261(a) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973 and June 30, 1974".

(j) Section 261(b) is amended (1) by striking out "nine fiscal years" and inserting in lieu thereof "ten fiscal years", and (2) by striking out "1973" and inserting in lieu thereof "1974."

(k) Section 264(c) of such Act is amended (1) by striking the words "June 30, 1973" and inserting in lieu thereof the words "June 30, 1973 and June 30, 1974" (2) by striking out "eight fiscal years" and inserting in lieu thereof "nine fiscal years", and (2) by striking out "July 1, 1973" and inserting in lieu thereof "July 1, 1974".

(l) Section 271(d) of such Act is amended by striking the phrase "for the fiscal year ending June 30, 1973" and inserting in lieu thereof the phrase "for each of the fiscal years ending June 30, 1973, and June 30, 1974".

(m) Section 271(d)(2) is amended (A) by striking out "eight fiscal years" and inserting in lieu thereof "nine fiscal years", and (B) by striking out "1973" and inserting in lieu thereof "1974".

(n) Section 272 is amended by striking out "1973" and inserting in lieu thereof "1974".

SEC. 4. Section 601 of the Act entitled "An Act to amend the Public Health Service Act to revise, extend, and improve the program established by title VI of such Act, and for other purposes" is, amended by striking "July 1, 1973" and inserting in lieu thereof "July 1, 1974".

SEC. 5. (a) Section 121(a) of the Developmental Disability Services and Facilities Construction Act is amended by striking out "for each of the next five fiscal years through the fiscal year ending June 30, 1973" and inserting in lieu thereof "for each of the next six fiscal years through the fiscal year ending June 30, 1974".

(b) Section 122(b) of such Act is amended by striking out "for the fiscal year ending June 3, 1973" and inserting in lieu thereof "for each of the fiscal years ending June 30, 1973, and June 30, 1974".

(c) Section 131 of such Act is amended by striking out "for the fiscal year ending June 30, 1973" and inserting in lieu thereof "for each of the fiscal years ending June 30, 1973, and June 30, 1974".

(d) Section 137(b)(1) of such Act is amended by striking "the fiscal year ending June 30, 1973," and inserting in lieu thereof "the fiscal years ending June 30, 1973, and June 30, 1974.".

SEC. 6. It is hereby declared to be the policy of the Federal Government, in the administration of all Federal programs, that religious beliefs or moral conviction regarding the performance of abortions or sterilization procedures (or limit the circumstances under which abortions or sterilizations may be performed) shall be respected.

SEC. 7. Any provision of law, regulation, contract, or other agreement to the contrary notwithstanding, on and after the enactment of the Act, there shall not be imposed, applied, or enforced, in or in connection with the administration of any program established or financed totally or in part by the Federal Government which provides or assists in paying for health care services for individuals or assists hospitals or other health care institutions, any requirement, condition, or limitation, which would result in causing or attempting to cause, or obligate, any physician, other health care personnel, or any hospital or other health care institution, to perform, assist in the performance of, or make facilities or personnel available for or to assist in the performance of, any abortion or sterilization procedure on any individual, if the performance of such abortion or sterilization procedure on such individual would be contrary to the religious beliefs or moral convictions of such physician or other health care personnel, or of the person or group sponsoring or administering such hospital or other institution.

SEC. 8. In respect of a hospital or other health care institution referred to in section 7 such hospital or other health care institution shall not discriminate in the employment, promotion, extension of staff or other privileges or termination of employment of any physician or other health care personnel on the basis of their personal religious or moral conviction regarding abortion or sterilization or their participation in such procedures.

SEC. 9. Any individual, hospital or other health care institution declining to participate in such procedures on the grounds of such religious or moral convictions shall post notice of such policy in a public place in such institution.

Mr. KENNEDY. Mr. President, I move to reconsider the vote by which the bill passed.

Mr. JAVITS. Mr. President, I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. KENNEDY. Mr. President, I want to express very briefly my appreciation to the ranking minority member of the Health Subcommittee, the Senator from Pennsylvania (Mr. SCHWEIKER) for the work he did in developing this legislation. I also thank the ranking minority member of the full Committee on Labor and Public Welfare, the Senator from New York (Mr. JAVITS), for his direction, counsel, and guidance. I also thank the chairman of the full Committee on Labor and Public Welfare, the Senator from New Jersey (Mr. WILLIAMS), who was enormously cooperative and helpful in the scheduling of the meetings and executive sessions and was of extremely valuable help and support.

I also thank the Senator from Colorado (Mr. DOMINICK), who was the former ranking minority member of the Health Subcommittee, and who also has been extremely helpful in health and other measures. His assistance was extremely useful.

Mr. President, I also wish to thank the staff members of the committee—Larry Horowitz, who did great work in the development of this legislation under the leadership of LeRoy Goldman, the staff director of the subcommittee. I also wish to thank Jay Cutler, who represents the minority. I doubt if there are harder working members of the staff of the Health Subcommittee or the full Committee on Labor and Public Welfare.

It is very significant to point out the excellent efforts on the part of all of these people.

I want to stress at this time, after the passage of the bill, we all recognize that a heavy responsibility goes to the committee in the redrafting of the Health Services Act. This work has already been started. The staff members have already spent a great deal of time on the selection of material and witnesses. We will have a full program outlined for us in the very near future.

We look forward to reporting back to the Senate—hopefully with the administration's support—a measure to provide more effective health programs for the American people.

BOARD OF DIRECTORS OF GALLAUDET COLLEGE—APPOINTMENT BY THE VICE PRESIDENT

The PRESIDING OFFICER (Mr. DOMENICI). The Chair on behalf of the Vice President, pursuant to Public Law 83-420, appoints the Senator from Iowa (Mr. CLARK) to be a member of the Board of Directors of Gallaudet College.

CANADA-UNITED STATES INTERPARLIAMENTARY MEETING—APPOINTMENT BY THE VICE PRESIDENT

The PRESIDING OFFICER (Mr. DOMENICI). The Chair, on behalf of the Vice President, pursuant to Public Law 86-42, appoints the Senator from Minnesota (Mr. HUMPHREY) to the Canada-United States Interparliamentary Meeting to be held in Washington, D.C., April 4 to 8, 1973.

EXHIBIT H

United States of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 109th CONGRESS, FIRST SESSION

Vol. 151 WASHINGTON, TUESDAY, JANUARY 25, 2005 No. 5

House of Representatives

The House met at 2 p.m.

The Chaplain, the Reverend Daniel P. Coughlin, offered the following prayer:

As we begin this regular session of the 109th Congress, the words of Deuteronomy demand our attention and spring into action the solemn oath sworn by Members of this Chamber to uphold the Constitution and serve God's people.

"Today you are making an agreement with the Lord: He is to be your God and you are to walk in His ways and observe His statutes, commandments and decrees, and to hearken to His voice.

"And today the Lord is making this agreement with you. You are to be a people especially His own, as He promised you; and provided you keep all His commandments, He will then raise you high in praise and renown and glory above all other nations He had made, and you will be a people sacred to the Lord your God."

Let the people say: Amen. Amen.

THE JOURNAL

The SPEAKER. The Chair has examined the Journal of the last day's proceedings and announces to the House his approval thereof.

Pursuant to clause 1, rule I, the Journal stands approved.

PLEDGE OF ALLEGIANCE

The SPEAKER. Will the gentleman from Texas (Mr. CUELLAR) come forward and lead the House in the Pledge of Allegiance.

Mr. CUELLAR led the Pledge of Allegiance as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

COMMUNICATION FROM THE CLERK OF THE HOUSE

The SPEAKER laid before the House the following communication from the Clerk of the House of Representatives:

WASHINGTON, DC,
January 25, 2005.

Hon. J. DENNIS HASTERT,
The Speaker, House of Representatives, Washington, DC.

DEAR MR. SPEAKER: Pursuant to the permission granted in Clause 2(h) of Rule II of the Rules of the U.S. House of Representatives, the Clerk received the following message from the Secretary of the Senate on January 25, 2005 at 9:07 a.m.:

That the Senate passed S. Res. 7.

Appointments:

Senate National Security Working Group;

Commission on Security and Cooperation in Europe.

With best wishes, I am

Sincerely,

JEFF TRANDAHL,
Clerk of the House.

HONORING THE LAKEVILLE HIGH SCHOOL MARCHING BAND

(Mr. KLINE asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. KLINE. Mr. Speaker, I rise today to recognize the efforts of a talented group of young men and women from my hometown of Lakeville, Minnesota.

Over 300 members of the Lakeville High School Panther Band made all Minnesotans proud with their outstanding performance last week in the Presidential Inaugural Parade. The skill and enthusiasm demonstrated by these 10th- through 12th-graders reflected well upon their director, Nathan Earp, and the families, teachers and fellow students who support them.

As a neighbor and a fan of the Marching Panthers, I was proud to watch them go by, and I am proud to pay tribute to them today.

HONORING THE OUTSTANDING CONTRIBUTIONS OF JOSEPH A. SCOTT, JR.

(Mr. CUELLAR asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. CUELLAR. Mr. Speaker, I rise today to honor the outstanding contributions of Joseph A. Scott, Jr., and to acknowledge a scholarship fund in his name recognizing his exceptional years of service to the people of San Antonio.

Joe paved the way for others and became the first African American in San Antonio to become a licensed insurance agent. He then went on to found World Technical Services, providing jobs for the disabled and those conquering substance abuse. He most recently served as a cofounder of the New Covenant Baptist Church.

Joe has also played an integral role in San Antonio politics, working closely with former President Lyndon B. Johnson, former mayor and HUD Secretary Henry Cisneros and the late Congressman Frank Tejeda.

Mr. Speaker, I am proud to have this opportunity to recognize the many accomplishments of Mr. Joseph A. Scott, Jr.

COMMENDING ERSKINE COLLEGE

(Mr. WILSON of South Carolina asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. WILSON of South Carolina. Mr. Speaker, I rise today to recognize Erskine College, the oldest 4-year, church-related college in South Carolina, which was founded by the Associate Reformed Presbyterian Church.

For over 106 years, Erskine's faculty and staff have created an environment of excellence, where students are taught to incorporate their first-class education and good moral values into

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million parts produced in electronics, and health care had an average of 10,000 defects per million. I do not mean that health care should be compared to the electronics industry, but 10,000 defects per million should be an unacceptable number.

We must begin to look at health care costs in a new way, focusing on overall health and not simply disease, emphasizing the need to move forward in integrated care.

The situation our constituents face every month when trying to pay for their health care insurance requires Congress to bring the information technology that touches every other aspect of our lives to the one area that may mean the most. We must promote ideas to bring the transformative power of information technology to every corner of our health care system in an effort to ensure quality, patient safety, and efficiency through bipartisan solutions.

This is just one of the many measures of quality we need to be addressing to make health care more affordable and accessible. As co-chairman of the 21st Century Health Care Caucus, I intend to come to this floor often during this session with new ways to reduce the cost of health care and offer tangible ways to decrease costs and improve patient safety, and I invite my colleagues to do the same.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 54, CONGRESSIONAL GOLD MEDAL ENHANCEMENT ACT OF 2005

Mr. SESSIONS, from the Committee on Rules, submitted a privileged report (Rept. No. 109–1) on the resolution (H. Res. 42) providing for consideration of the bill (H.R. 54) to amend title 31, United States Code, to provide reasonable standards for congressional gold medals, which was referred to the House Calendar and ordered to be printed.

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Oregon (Mr. BLUMENAUER) is recognized for 5 minutes.

(Mr. BLUMENAUER addressed the House. His remarks will appear hereafter in the Extension of Remarks.)

CELEBRATING 100 YEARS OF THE ROTARY CLUB OF CHICAGO'S SERVICE

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Illinois (Mr. DAVIS) is recognized for 5 minutes.

Mr. DAVIS of Illinois. Mr. Speaker, on February 23, 1905, Paul Harris, a Chicago attorney, invited three friends to a meeting: Sylvester Schiele, a coal dealer; Hiram Shorey, a merchant tailor; and Gustavus Loehr, a mining engineer. All four men gathered in Loehr's business office in room 711 of the Unity Building at 127 North Dearborn Street in downtown Chicago, which is my district. They discussed Harris' idea that business needed to meet periodically to enjoy camaraderie and to enlarge the circle of business and professional acquaintances.

The club met weekly. Membership was limited to one representative from each business and profession. Though the men did not use the term "rotary" that night, that gathering is commonly regarded as the first Rotary Club meeting. The name "rotary" was suggested later on by Paul Harris as meetings were rotated from office to office in the early days of the organization.

During the early days, the Rotarians realized that fellowship and mutual self-interest were not enough to keep a club of busy professionals meeting each week. Reaching out to improve the lives of the less fortunate proved to be an even more powerful motivation. The Rotary commitment to service began when the Rotary Club of Chicago donated a horse to a preacher so that he could make the rounds of his churches and parishioners. A few weeks later, the club constructed Chicago's first public lavatory. These actions of service and improvement of communities continued in 1967 to support the pediatric program at the Rehabilitation Institute of Chicago.

Of course, through the years, these services have continued and they have continued to make valuable contributions to the most needy members of our society.

So, Mr. Speaker, I warmly congratulate the Rotary Club of Chicago for 100 years of service, making a difference in the lives of the less fortunate and showing the true commitment of business leaders to strengthen our local and global communities. I wish the club another 100 years of service and Tuesday lunches in downtown Chicago.

ABORTION CLINICS: NOT ONLY KILLING MILLS BUT TORTURE CENTERS AS WELL

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from New Jersey (Mr. SMITH) is recognized for 5 minutes.

Mr. SMITH of New Jersey. Mr. Speaker, yesterday, 100,000 human rights advocates endured the numbing cold and snow in a great witness for life here in our Nation's Capital. Their presence on behalf of those who have no voice of their own was truly inspiring. It was gratifying beyond words to see so many teenagers full of idealism and full of compassion and love for their littlest brothers and sisters and for all human life that is at risk.

Indeed, Mr. Speaker, the pro-life movement is the greatest human rights movement on Earth.

□ 1945

Mr. SMITH of New Jersey. It is a struggle based on unconditional love, even for the proabortionists, unconditional empathy for the victims, both the child and his or her mother, and unconditional courage.

We are a movement with deep hope and expectation, that with God's all-powerful grace, and through that all-powerful grace, the culture of death will soon be vanquished by the culture of life, where all human life is cherished and respected. We pray for the day when branding an unborn child as unwanted will no longer mean a death sentence in America.

Mr. Speaker, I have always found the term "unwanted child" dehumanizing, for it relegates a child to the status of a commodity, an object, a thing, something that can be chosen or unchosen at will, not unlike any other consumer product.

Mr. Speaker, with each passing year, the horrific toll of abortion on women's lives becomes more evident, and it is time the media especially stopped censoring the truth. Women deserve better than abortion, and the compelling stories of the brave women, the postabortive women who are silent no more need to be heard. These very special women bear witness not only to the agony and the trauma of their own abortions, but to the hope of healing, reconciliation and inner peace as well.

Wounded women like Dr. Alveda King, the niece of the late Dr. Martin Luther King, who has had an abortion, Jennifer O'Neill, singer Melba Moore, civil rights activist, like I said, Dr. King, and so many others, and cofounder of this group called Silent No More Awareness Campaign, Georgette Forney, have all called on us to listen to their heart-wrenching stories and take seriously our moral duty to protect women and children from the predators who ply their lethal trade in abortion mills throughout the land.

These brave women are the new champions of life. They have refused to be silent any longer. They care too deeply about other women and their children, and they want others to be spared the anguish that they themselves have endured. And to the millions of women who have aborted, they are uniquely equipped to convey the breathtaking love and healing and reconciliation that God provides to those who ask. They do have a connection, the silentnomoreawareness.org, if those who might want to contact them just go on the Web and check them out. They are unbelievably full of compassion.

Mr. Speaker, let me also point out that with each passing year, the child body count from abortion in America grows. Since the infamous decision in 1973, more than 46 million babies have been killed by dismemberment or chemical poisoning, a number fast approaching the total worldwide deaths attributable to World War II; that is civilian and military deaths.

And as we have feared, Mr. Speaker, the much touted baby pesticide, RU–486, rushed to approval by a very biased

FDA, is poison not only to the baby, but women are dying from it as well.

And now we learn, Mr. Speaker, from science and medicine that due to nerve cell development, unborn children from at least 20 weeks onward, and most likely even earlier, feel excruciating pain, two to four times more painful than you or I would feel from the same assault.

Today, along with 75 cosponsors, I have reintroduced legislation, the Unborn Child Pain Awareness Act, to require in part that women seeking abortions at this stage of development be informed of this gruesome reality. These kids feel pain, and we need to make that known to those women who are procuring abortions at that gestational period.

The bill would also require that women be given the option of having anesthesia administered directly to the unborn child, because indirect administration does not cross the placenta to numb the pain that the child feels as they are being slowly dismembered by these later-term abortion methods. One of those methods, the D and E, takes about 30 minutes as the arms and the legs and the body and the torso are all hacked off. And the baby feels pain during this hideous procedure.

Interestingly, Mr. Speaker, the partial-birth abortion legal trials in various courts around the country drew new attention to the pain that unborn children feel during an abortion. In expert testimony during these trials, Dr. Sunny Anand, Director of the Pain Neurobiology Lab at Arkansas Children's Hospital, said, and I quote him, "The human fetus possesses the ability to experience pain from 20 weeks of gestation, if not earlier, and the pain that is perceived by a fetus is more intense than that perceived by newborns or older children."

He went on to explain that the pain inhibitory mechanisms, in other words the fibers that dampen and modulate the experience of pain, do not begin to develop until 32 to 34 weeks of gestation. Thus these children feel pain, and they feel it excruciatingly so.

Abortion is violence against children, Mr. Speaker, and these kids feel that pain.

Abortion clinics, if we look at them as what they really are, are not only killing centers, they are torture chambers as well. I hope that we all can move on this legislation as quickly as possible.

HONOR THY FATHER AND THY MOTHER

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Ohio (Ms. KAPTUR) is recognized for 5 minutes.

Ms. KAPTUR. Mr. Speaker, the theme for my remarks tonight is honor thy father and thy mother. The Congressional Budget Office has confirmed, and I might say they are nonpartisan, that the projected budget deficit for this year for our country will be over $368 billion, not even counting the additional $80 billion that will be added to that when bills come before this Congress for additional funding for Iraq and Afghanistan. Though these dollars literally are coming from the Social Security Trust Fund itself, the Congressional Budget Office noted that last year was the largest deficit in the history of our Nation, $412 billion, is the reason that the dollar value of currency is dropping. In fact, if we add up the last 3 years, we have the largest budget deficit in the history of the Republic.

When President Bush came into office, there was a $5.6 trillion surplus. In fact, I thought it was rather funny at the time, Alan Greenspan was starting to get worried that we might actually pay our bills. He was a little uncomfortable that maybe the bond market would not be completely happy. What would we do if we paid all our bills?

But now we have a $2.6 trillion deficit. That is a reversal of nearly $3 trillion. It is obvious this administration and their allies in the Congress cannot handle the pursestrings of this Nation.

The very same people who brought us this fiscal train wreck, which is getting worse, are now proposing radical surgery on Social Security. Nothing President Bush has attempted to date, not even his incessant effort to shift the tax burden off the shoulders of the rich onto the middle class, is as brazen and audacious as his misguided efforts to try to gut Social Security.

There is no crisis in Social Security. Repeat, there is no crisis in Social Security. There is only a crisis in the Bush administration's handling of the budget. Why would anyone trust the Bush administration on anything regarding Social Security, seeing that they are a miserable failure in terms of the management of the account of the people of the United States?

Social Security is the most successful domestic program in the modern history of our Nation. Approximately 45 million Americans receive their Social Security insurance benefits and disability benefits. Just over 7 million of those are disability recipients. In the State that I am from, Ohio, 1,922,406 individuals receive Social Security insurance benefits and 208,000 disability benefits.

We do not know what is going to happen to our families. One out of five families in this country are going to have an unforeseen happening that will require eligibility for disability. There is no private sector policy that will ever offer it. These are insurance and disability benefits. They are not private accounts. They are not 401(k)s. They are not certificates of deposit. This is an insurance and disabilities program. It has always been that.

The Congress voted repeatedly not to allow the executive branch to dip into the trust fund, and yet that is exactly what is happening today. The President is trying to whip up a frenzy in the country and say the sky is falling, the sky is falling, trying to scare America's seniors and our young people who are going to get old someday into thinking Social Security is in crisis. Even the head of the AARP has said Social Security is not in crisis, the program will remain solvent, and what we have to do over the next 50 years is just to make sure that the gap financing that is there will cover future beneficiaries.

We can do that in several ways. We have done it before. We can do it again. In fact, what is interesting, the Bush administration's four enacted tax cuts being made permanent would cost 2 percent of GDP over the next 75 years, which is three to five times as much as any of Social Security's future financing needs. Under their plan, instead of benefits being tied to prevailing standards of living during the course of a worker's career, the change would freeze Social Security benefits at today's standard of living, which means we would keep regressing backwards, and future generations of retirees would have lower and lower benefits compared to their wages during their working lives.

This cut would apply to all beneficiaries whether or not they had chosen to have a private account. It should not be an either/or, private accounts or Social Security. It should be both, and make sure Social Security is solvent. Stop borrowing against it. And fine, let us encourage private savings like we used to in this country up until the last few years.

Social Security should be a guarantee, an insurance guarantee and a disability guarantee, as Democrats have not only promised but have delivered from the time of Franklin Roosevelt. Social Security should be a guarantee, not a gamble.

Let me end with the words to the Republicans, I can only say if they want to fight on Social Security, bring it on, because this Member intends to honor thy father and thy mother.

ABORTION

The SPEAKER pro tempore (Mr. BURGESS): Under a previous order of the House, the gentleman from Florida (Mr. WELDON) is recognized for 5 minutes.

Mr. WELDON of Florida. Mr. Speaker, the foundation of American democracy is freedom. In particular, as Americans we are all free to choose or decline issues of conscience, but regarding abortion, choice is losing in a way that may surprise many people.

Such is the case regarding physicians, hospitals and health plans that choose not to perform, pay for or refer for abortions. From Alaska to New Jersey, abortion advocacy groups are forcing health care entities to do the very thing they would not if they had the choice. Abortion advocates are using the courts, State and local agencies and laws to mandate that abortions be performed, paid for and referred for.

In July of 2002, an Alaska court forced a community hospital to provide elective, non-life-threatening, late-term abortions contrary to its policy. In New Jersey, abortion advocacy groups urged the State of New Jersey to require a Catholic health system to build an abortion clinic on its premises. Last year, the State of New Mexico refused to approve a hospital lease because the hospital-owned system declined to perform elective abortions.

Such coercion is wrong and should not be permitted, particularly with Federal taxpayer dollars. *Roe* v. *Wade* created a woman's right to an abortion. Today Federal law requires that an abortion be provided to a woman in a life-threatening situation, but in a perverse concerted effort, radical advocates for abortion are engaging in legislative and court efforts to coerce health care providers, health plans and clinics to provide, pay for and refer for elective, non-life-threatening abortions.

In July of last year, I offered an amendment during committee consideration of the Labor-HHS appropriation bill to stop this coercion. This provision was included in the bill when it came to the floor of the House, to which no one objected. It was then included in the final consolidated appropriation bill for 2005.

The Hyde-Weldon amendment is simple. It prevents Federal funding when courts and other government agencies force or require physicians, clinics and hospitals and health insurers to participate in elective abortions. My amendment in no way infringes on a woman's ability to seek and receive elective abortions. It simply states you cannot force the unwilling.

The amendment does not apply to willing abortion providers. Hyde-Weldon allows any health care entity to participate in abortions in any way they choose.

□ 2000

It simply prohibits coercion in nonlife-threatening situations.

But there is the rub. People who call themselves prochoice want no tolerance afforded toward health care entities that desire their rights of conscience be respected. Sadly, radical abortion advocates only support choice on their terms and are more than willing to use the coercive power of government to advance their agenda. Their true mantra seems to be: safe, legal, and coerced.

It is predictable that abortion advocates would look to the courts to enforce their bizarre notion that abortion should not be provided just by the willing but also the unwilling, and that is just what has happened today. In California, Attorney General Lockyer filed a lawsuit against the Hyde-Weldon amendment. He makes a number of assertions in the complaint, and I want to look at some of them right now.

Interestingly, Mr. Lockyer seems to be eager to reserve the right of the State to coerce an unwilling health care provider to participate in an elective abortion, despite the fact their own State law prohibits them, and which my amendment attempts to provide such protection to all health care providers nationally.

In the 26-page complaint, the California Attorney General fails to point to even one example of a single case supporting the assertion that the Hyde-Weldon amendment would somehow interfere with the State's desire to see abortion services offered as an emergency medical service. The complaint offers no specific case where an emergency situation required an abortion in which a health care provider refused on grounds of conscience. Why? Because it does not happen. The bulk of the rhetoric in the complaint is about this very speculative scenario.

The question I have for the California Attorney General is: Prior to my amendment, was California compelling non-willing providers to perform emergency abortions? If no, then the Attorney General has nothing to fear from my amendment because that is all it addresses. If the answer is yes, then the Attorney General wishes to protect this practice as evidenced by his desire to litigate over it.

In fact, if the answer is yes, the Attorney General is ready to subordinate all other spending priorities in his State to defend his position of coerced abortions.

In this court filing he raises the notion that women will die because they will not have access to an abortion needed to save the life of the mother. Hyde-Weldon does nothing of the sort. It ensures that in situations where a mother's life is in danger a health care provider must act to protect the mother's life.

In fact, Congress passed the Federal Emergency Medical Treatment and Active Labor Act (EMTALA) forbidding critical-care health facilities to abandon patients in medical emergencies, and requires them to provide treatment to stabilize the medical condition of such patients—particularly pregnant women.

The bottom line is that this lawsuit seems to be more about politics and using the coercive power of the state for forced participation in abortion, rather than ensuring that pregnant women in emergency situations have access to life-saving care.

IRAQ SUPPLEMENTAL AND TROOPS

The SPEAKER pro tempore (Mr. BURGESS). Under a previous order of the House, the gentleman from New Jersey (Mr. PALLONE) is recognized for 5 minutes.

Mr. PALLONE. Mr. Speaker, today we learn the Bush administration plans to ask Congress for another $80 billion in emergency funds for the war in Iraq and Afghanistan. This $80 billion comes on top of an additional $200 billion that we have spent in Iraq since the beginning of the war 2 years ago.

Mr. Speaker, the Bush administration never leveled with the American people about the kind of sacrifices they would have to make in order to fight this war. You will remember that before the war, President Bush and his war cabinet said the sacrifices would be minimal. They falsely claimed the majority of the war costs could be paid for by the royalties Iraq received on the sale of its oil. Nearly 2 years have passed since the beginning of the war, and we have yet to see one cent from the sale of Iraqi oil.

You would think my Republican colleagues, particularly the ones who repeatedly come to the well of the floor to rail against the waste, fraud, and abuse in our Federal Government, would be demanding some accountability from the administration about the cost of the war. You would think they would be calling for congressional hearings demanding to hear from Defense Secretary Rumsfeld on exactly where the Pentagon spent the $200 billion Congress already appropriated for the war.

Unfortunately, Republicans have abdicated their oversight responsibility and are giving the Bush administration a free ride on the enormous miscalculations we have all witnessed in the Iraq war.

Mr. Speaker, during World War II, then Senator Harry Truman created a war investigating committee charged with exposing any fraud or mismanagement in our Nation's war efforts in both the Pacific and the Atlantic. Truman was, of course, a Democratic Senator serving in a Democratic Senate majority, overseeing the Democratic administration of President Franklin Roosevelt. Truman never worried about the fact he was investigating a President of his own party. He refused to allow politics to get in the way of good government; and as a result, his investigations saved the American taxpayer more than $15 billion.

Now, that was a lot of money back in the 1940s, and it is still a lot of money today. But I wonder just how much more money we could save the American taxpayer if congressional Republicans took their oversight responsibility seriously.

Where is the Republican Party's Harry Truman? Why are congressional Republicans so worried about asking the Bush administration for specifics on where it is spending the $200 billion Congress has already appropriated? Could it be that congressional Republicans are afraid of what they would uncover if they looked too closely into the administration's handling of the war?

The Bush administration has awarded Vice President CHENEY's old company, Halliburton, billions of dollars of no-bid contracts since the beginning of the war. Despite the lack of congressional oversight, we discovered that Halliburton was charging for meals it never served our troops. Obviously, that is a waste of America's taxpayers' money. How many other examples of fraud and abuse are out there?

Mr. Speaker, I opposed giving President Bush the authority to begin this

EXHIBIT I

United States of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 104th CONGRESS, SECOND SESSION

Vol. 142 WASHINGTON, TUESDAY, MARCH 19, 1996 No. 38

Senate

The Senate met at 9 a.m., and was called to order by the Honorable TED STEVENS, a Senator from the State of Alaska.

The PRESIDING OFFICER. We will now have a prayer from Father Paul E. Lavin from St. Joseph's Church on Capitol Hill.

PRAYER

The guest Chaplain, the Reverend Paul E. Lavin, offered the following prayer:

Let us join millions of our fellow citizens and millions of others in faith communities around the world who today honor the memory of Joseph, spouse of Mary, Foster father and faithful guardian of Jesus. We listen to the words of Scripture whioh he surely found a support in his life, from the Book of Wisdom (10:10–11).

Wisdom, when the just man was in flight, guided him in direct ways,
Showed him the Kingdom of God and gave him the knowledge of holy things;
She prospered him in his labors and made abundant the fruit of his worke.

Let us pray:

Good and gracious God, give the men and women of this Senate and give their staffs the inspiration to listen carefully to Your word here, in their homes, and in their own faith communities; support them when they experienoe doubts and fears; and embolden them to live their lives in response to Your word, and ultimately to be obedient to Your word, as was Joseph. Guide these Senators by Your wisdom, support them by Your power, and keep them faithful to all that is true, glory and praise to You forever and ever. Amen.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The olerk will please read a communication to the Senate from the President pro tempore [Mr. THURMOND].

The assistant legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, March 19, 1996.

To the Senate:

Under the provisions of rule I, section 3, of the Standing Rules of the Senate, I hereby appoint the Honorable TED STEVENS, a Senator from the State of Alaska, to perform the duties of the Chair.

STROM THURMOND,
President pro tempore.

Mr. STEVENS thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE ACTING MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The acting majority leader is reoognized.

SCHEDULE

Mr. LOTT. This morning the Senate will immediately resume consideration of H.R. 3019, the omnibus appropriations bill. Under a previous order, there will be a total of 3 hours of controlled debate on the Boxer amendment No. 3508 and the Coats amendment No. 3513, both amendments regarding the subjeot of abortion. Following the expiration or yielding back of that time, the Senate will resume consideration of the Murkowski amendment No. 3525 regarding Greens Creek.

The Senate will stand in recess between the hours of 12:30 p.m., and 2:15 p.m., in order to accommodate the respective party luncheons. When the Senate reconvenes at 2:15 p.m., there is expected to be a series of rollcall votes on or in relation to amendments and passage of the omnibus appropriations bill, H.R. 3019. Senators are also reminded that at some point during today's session the Senate will be voting on the motion to invoke cloture on the motion to proceed to Senate Resolution 227 regarding authority for the Special Committee To Investigate the Whitewater Matter; passage of S. 942, the small business regulatory reform bill, and possibly a vote on the motion to invoke cloture on the product liability conference report unless a unanimous consent can be reached to the contrary.

Mr. President, I yield the floor.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

BALANCED BUDGET DOWNPAYMENT ACT, II

The ACTING PRESIDENT pro tempore. Under the previous order, the Chair lays before the Senate H.R. 3019, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (H.R. 3019) making appropriations for fiscal year 1996 to make a further downpayment toward a balanced budget, and for other purposes.

The Senate resumed the consideration of the bill.

Pending:

Hatfield modified amendment No. 3466, in the nature of a substitute.

Lautenberg amendment No. 3482 (to amendment No. 3466), to provide funding for programs necessary to maintain essential environmental protection.

Boxer-Murray amendment No. 3508 (to amendment No. 3466), to permit the District of Columbia to use local funds for certain activities.

Gorton amendment No. 3496 (to amendment No. 3466), to designate the "Jonathan

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

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M. Wainwright Memorial VA Medical Center", located in Walla Walla, Washington.

Simon amendment No. 3511 (to amendment No. 3466), to provide funding to carry out title VI of the National Literary Act of 1991, title VI of the Library Services and Construction Act, and section 109 of the Domestic Volunteer Service Act of 1973.

Coats amendment No. 3513 (to amendment No. 3466), to amend the Public Health Service Act to prohibit governmental discrimination in the training and licensing of health professionals on the basis of the refusal to undergo or provide training in the performance of induced abortions.

Bond (for Pressler) amendment No. 3514 (to amendment No. 3466), to provide funding for a Radar Satellite project at NASA.

Bond amendment No. 3515 (to amendment No. 3466), to clarify rent setting requirements of law regarding housing assisted under section 236 of the National Housing Act to limit rents charged moderate income families to that charged for comparable, non-assisted housing, and clarify permissible uses of rental income is such projects, in excess of operating costs and debt service.

Bond amendment No. 3516 (to amendment No. 3466), to increase in amount available under the HUD Drug Elimination Grant Program for drug elimination activities in and around federally-assisted low-income housing developments by $30 million, to be derived from carry-over HOPE program balances.

Bond amendment No. 3517 (to amendment No. 3466), to establish a special fund dedicated to enable the Department of Housing and Urban Development to meet crucial milestones in restructuring its administrative organization and more effectively address housing and community development needs of States and local units of government and to clarify and reaffirm provisions of current law with respect to the disbursement of HOME and CDBG funds allocated to the State of New York.

Santorum amendment No. 3484 (to amendment No. 3466), expressing the Sense of the Senate regarding the budget treatment of federal disaster assistance.

Santorum amendment No. 3485 (to amendment No. 3466), expressing the Sense of the Senate regarding the budget treatment of Federal disaster assistance.

Santorum amendment No. 3486 (to amendment No. 3466), to require that disaster relief provided under this Act be funded through amounts previously made available to the Federal Emergency Management Agency, to be reimbursed through regular annual appropriations Acts.

Santorum amendment No. 3487 (to amendment No. 3466), to reduce all title I discretionary spending by the appropriate percentage (.367%) to offset Federal disaster assistance.

Santorum amendment No. 3488 (to amendment No. 3466), to reduce all title I "Salary and Expense" and "Administrative Expense" accounts by the appropriate percentage (3.5%) to offset Federal disaster assistance.

Gramm amendment No. 3519 (to amendment No. 3466), to make the availability of obligations and expenditures contingent upon the enactment of a subsequent act incorporating an agreement between the President and Congress relative to Federal expenditures.

Wellstone amendment No. 3520 (to amendment No. 3466), to urge the President to release already-appropriated fiscal year 1996 emergency funding for home heating and other energy assistance, and to express the sense of the Senate on advance-appropriated funding for fiscal year 1997.

Bond (for McCain) amendment No. 3521 (to amendment No. 3466), to require that disaster funds made available to certain agencies be allocated in accordance with the established prioritization processes of the agencies.

Bond (for McCain) amendment No. 3522 (to amendment No. 3466), to require the Secretary of Veterans Affairs to develop a plan for the allocation of health care resources of the Department of Veterans Affairs.

Warner amendment No. 3523 (to amendment No. 3466), to prohibit the District of Columbia from enforcing any rule or ordinance that would terminate taxicab service reciprocity agreements with the States of Virginia and Maryland.

Murkowski-Stevens amendment No. 3524 (to amendment No. 3466), to reconcile seafood inspection requirements for agricultural commodity programs with those in use for general public consumers.

Murkowski amendment No. 3525 (to amendment No. 3466), to provide for the approval of an exchange of lands within Admiralty Island National Monument.

Warner (for Thurmond) amendment No. 3526 (to amendment No. 3466), to delay the exercise of autbority to enter into multiyear procurement contracts for C-17 aircraft.

Burns amendment No. 3528 (to amendment No. 3466), to allow the refurbishment and continued operation of a small hydroelectric facility in central Montana by adjusting the amount of charges to be paid to the United States under the Federal Power Act.

Coats (for Dole-Lieberman) amendment No. 3531 (to amendment No. 3466), to provide for low-income scholarships in the District of Columbia.

Bond-Mikulski amendment No. 3533 (to amendment No. 3482), to increase appropriations for EPA water infrastructure financing, Superfund toxic waste site cleanups, operating programs, and to increase funding for the Corporation for National and Community Service (AmeriCorps).

Hatfield (for Burns) amendment No. 3551 (to amendment No. 3466), to divide the ninth judicial circuit of the United States into two circuits.

Burns amendment No. 3552 (to amendment No. 3551), to establish a Commission on restructuring the circuits of the United States Courts of Appeals.

AMENDMENT NO. 3513

The ACTING PRESIDENT pro tempore. Under the time agreement on these amendments, there is 1 hour now allocated to the Senator, from Indiana [Mr. COATS]. The amendment is now before the Senate.

Mr. COATS. Mr. President, thank you.

Last week, as we were looking at potential amendments for this legislation, the issue of the potential discrimination that might exist regarding payments from the Federal Government to medical hospitals and to individual residents in training, loans, and other Federal assistance that is available for these individuals and these institutions, was threatened by potential loss of accreditation to these institutions as a result of the Accrediting Council on Graduate Medical Education's change in their requirements for accreditation to mandate the training in abortion techniques.

Previously, this had been done on a voluntary basis. Many hospitals, for a number of reasons, whether they are religious reasons, moral reasons or just purely decisions on the basis of the board of directors or governors of these institutions, determined that they would not have a mandatory program of abortion training. Voluntary programs existed. Those who sought that training had access and could receive that training, but it was not mandated.

The change in regulations on the part of the Accrediting Council on Graduate Medical Education threatened to withdraw accreditation from many of these institutions unless they opted out under a so-called conscience or moral clause. It was my feeling and the feeling of many that this opt-out clause was not sufficient to address the concerns of a number of institutions, particularly nonreligious-based institutions. So I offered an amendment last week which was designed to clarify this.

That amendment essentially said that any State or local government that receives financial assistance should not subject any health care entity to discrimination on the basis that the entity refused to undergo training in the performance of induced abortions or to require or provide such training to perform such abortions or provide referrals for the training for such abortions.

We, in discussion with a number of other Senators, came across a possible misinterpretation of the exceptions to the section that basically said that nothing in this amendment that I am offering should in any way restrict or impede the accrediting council from making that accreditation. The concern was, if I state it correctly, that we would lose a valuable means of examining the various programs that existed in hospitals and resident training programs for determination of whether or not the Government should participate. It is legitimate that we have an accrediting process on which we can rely. What I was trying to do with my amendment was simply address the question of training for induced abortions.

We had exceptions to that which basically stated that nothing in this act should prohibit the accrediting agency or a Federal, State, or local government from establishing standards of medical competency applicable to those individuals who voluntarily elected to perform abortions or prevent any health care entity from voluntarily electing to be trained or arrange for training in the performance of or referrals for induced abortions.

We have had numerous discussions with the Senator from Maine relative to this language. Some negotiations over the weekend have resolved this. It preserves the entire impact of the Coats amendment and yet addresses and clarifies the concerns of the Senator from Maine. So I am pleased to announce this morning that we have reached agreement on this amendment. The amendment will be cosponsored by the Senator from Maine. We resolved the language differences. It also addresses an issue of second-degree, which would have prolonged the debate

on this important broader bill, and so I am happy to report to my colleagues that we will be able to free up some time on that basis for disoussion of the amendment that is offered by the Senator from California, Senator BOXER.

The Senator from Maine is present this morning, and I know she has some comments to make in this regard. Let me say this. The Senator from Tennessee, Senator FRIST, has been instrumental in helping us first understand the accrediting process and the importanoe of the acorediting process. As a medical doctor, he has some knowledge and personal experience with this issue and these questions that I cannot begin to bring to the debate. He and his staff have been immensely helpful in helping us to draft this legislation so we can accomplish what we intended to accomplish, but also retain the integrity of the accrediting process.

I am very happy to yield to him. I will yield whatever time the Senator from Tennessee desires in order to speak to this amendment.

The ACTING PRESIDENT pro tempore. The chair did not hear the Senator seek to modify his amendment.

Mr. COATS. Mr. President, this is an appropriate time to ask unanimous-consent to modify my amendment. I send that modification to the desk.

Mrs. BOXER. I object.

The ACTING PRESIDENT pro tempore. There are no yeas and nays ordered, so the Chair is corrected. Sinoe there is a time agreement, it takes unanimous consent.

Mrs. BOXER. I objeot at this time.

The ACTING PRESIDENT pro tempore. Objeotion is heard.

Mr. COATS. Mr. President, I will discuss this modification with the Senator from California and, hopefully, we can resolve the question here. At the present time, I want to yield time to the Senator from Tennessee.

I will withhold the unanimous-consent request at this time so I can disouss it with the Senator from California.

I yield whatever time the Senator from Tennessee needs.

The ACTING PRESIDENT pro tempore. The Senator from Tennessee.

Mr. FRIST. Mr. President, I commend the Senator from Indiana for his thoughtful approach to this important issue. My colleague has proposed an amendment that will protect medioal residents, individual physicians, and medical training programs from abortion-related discrimination in the training and licensing of physicians. However, in our efforts to safeguard freedom of conscience, there are limits to what Congress should impoee on private medical aocrediting bodies. I believe this amendment stays within the confines of the governmental role and addresses the matter of discrimination in a way that is acceptable to all parties.

This amendment states that the Federal Government, and any State that receives Federal health financial assistanoe, may not discriminate against any medical resident, physician, or medioal training program that refuses to perform or undergo training and induced abortions, or to provide training or referrals for training in induced abortions.

Discrimination is defined to include withholding legal status or failing to provide financial assistance, a service, or another benefit simply because an unwilling health entity is required by certain accreditation standards to engage in training in or the performance of induced abortions.

The primary concern that occurs when one addresses any accreditation issue is that quality of care will be sacrificed. As a physician, the oare of patients is my highest priority, and this amendment specifically addresses this issue. It makes it clear that health entities would still have to go through the accreditation process, and that their policy with regard to providing or training in induced abortion would not affect their Government-provided finanoial assistance, benefits, services, or legal status.

The Government would work with the accrediting agency to deem schools accredited that—and I quote from the amendment—"would have been accredited but for the Agency's reliance upon a standard that requires an entity to perform an induced abortion, or require, provide, or refer for training in the performance of induced abortions or make arrangements for suoh training."

Mr. President, this amendment arose out of a controversy over accrediting standards for obstetrical and gynecological programs. The Acoreditation Counoil for Graduate Medical Education, the ACGME, is a private body that establishes and enforcee standards for the medical community. As a physician, I deeply respect and appreoiate the ACGME, and I understand the fundamental need for quality medioal standards and oversight.

Moreover, I feel strongly that the Federal Government should not dictate to the private seotor how to run their programs. We must not usurp the private aocreditation process. But, at the same time, Congress is responsible for the Federal funding that is tied to acoreditation by the ACGME, and as publio servante, we must ensure that there is no hint of discrimination associated with the use of public funds.

I am pleased, Mr. President, that we could work together to address the legitimate concerns of both sides in crafting this amendment. I join with the Senator from Indiana and the Senator from Maine in supporting this amendment, which will prevent discrimination with respect to abortion, but preserve the integrity of the accreditation process.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. THOMAS). Who yields time?

Mr. FRIST. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. COATS. Mr. President, I ask unanimous consent that the order for the quorum call be resoinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. COATS. Mr. President, I ask unanimous consent that the time that is now running during any quorum call be equally divided between both sides.

The PRESIDING OFFICER. Is there objeotion?

Without objection, it is so ordered.

Mr. COATS. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. CAMPBELL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. CAMPBELL. Mr. President, I ask unanimous consent that I be allowed to speak as in morning business for a period of 4 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

AUTHORIZING THE SPECIALTY EQUIPMENT MARKET ASSOCIATION TO STAGE AN EVENT ON THE CAPITOL GROUNDS

Mr. CAMPBELL. Mr. President, I want to speak briefly with regard Senate Concurrent Resolution 44, a resolution which I and several colleagues submitted last week, that would reauthorize the Specialty Equipment Market Assooiation, in oonsultation with the Architeot of the Capitol, to stage an event on the Capitol Grounds on May 15.

As a motor enthusiast, I believe it is important to recognize the oontributions the motor sports induetry has made to improve the quality, performance and, more importantly, the safety of most all motor vehicles on the road today. Certainly, the American public has demonstrated a oontinuing love affair with motor vehicles since their introduction over 100 years ago in this country, enjoying vehicles for transportation and recreational endeavors, ranging from raoing to show competitions, and as the way of creating individual expression that has been extremely popular in the last 100 years.

In addition, research and development connected with motor sports competition and specialty applications has provided oonsumers with such life-saving safety mechanisms, including seatbelts, airbags, and many other important innovations.

As a result, the motor sports industry has grown tremendously over the years, where today hundreds of thouoands of amateur and professional participants enjoy motor sports competitions eaoh and every year throughout

the United States, attracting attendance in excess of 14 million people, making the motor sports industry one of the most widely attended of all U.S. sports. And equally important, as an economic engine, sales of motor vehicle performance and appearance enhancement parts and accessories annually exceeds $15 billion, and employ nearly 500,000 people.

Mr. President, Senate Concurrent Resolution 44 seeks to authorize the Specialty Equipment Market Association, in consultation with the Architect of the Capitol and the Capitol Police Board, to conduct an event to showcase innovative automotive technology and motor sports vehicles on the Grounds of the Capitol on May 15 of this year.

I hope my colleagues will share in the recognition of the motor sports industry and support Senate Concurrent Resolution 44.

I yield the floor.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

Mr. COATS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

BALANCED BUDGET DOWNPAYMENT ACT, II

The Senate continued with the consideration of the bill.

AMENDMENT NO. 3513, AS MODIFIED

Mr. COATS. Mr. President, earlier this morning I proposed a unanimous-consent request to modify the amendment which I had offered last week, on Thursday, to the legislation that the Senate is currently considering. We have had some discussion with the Senator from California and others regarding this. I believe we have resolved concerns relative to this modification, at least regarding offering the unanimous-consent request.

So I now repeat my unanimous-consent request to modify the pending amendment to H.R. 3019.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

The amendment (No. 3513), as modified, is as follows:

At the appropriate place, insert the following:

SEC. . ESTABLISHMENT OF PROHIBITION AGAINST ABORTION-RELATED DISCRIMINATION IN TRAINING AND LICENSING OF PHYSICIANS.

Part B of title II of the Public Health Service Act (42 U.S.C. 238 et seq.) is amended by adding at the end the following section:

"ABORTION-RELATED DISCRIMINATION IN GOVERNMENTAL ACTIVITIES REGARDING TRAINING AND LICENSING OF PHYSICIANS

"SEC. 245. (a) IN GENERAL.—The Federal Government, and any State or local government that receives Federal financial assistance, may not subject any health care entity to discrimination on the basis that—

"(1) the entity refuses to undergo training in the performance of induced abortions, to require or provide such training, to perform such abortions, or to provide referrals for such training or such abortions;

"(2) the entity refuses to make arrangements for any of the activities specified in paragraph (1); or

"(3) the entity attends (or attended) a post-graduate physician training program, or any other program of training in the health professions, that does not (or did not) perform induced abortions or require, provide or refer for training in the performance of induced abortions, or make arrangements for the provision of such training.

"(b) ACCREDITATION OF POSTGRADUATE PHYSICIAN TRAINING PROGRAMS.—

"(1) IN GENERAL.—In determining whether to grant a legal status to a health care entity (including a license or certificate), or to provide such entity with financial assistance, services or other benefits, the Federal Government, or any State or local government that receives Federal financial assistance, shall deem accredited any post-graduate physician training program that would be accredited but for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether such standard provides exceptions or exemptions. The government involved shall formulate such regulations or other mechanisms, or enter into such agreements with accrediting agencies, as are necessary to comply with this subsection.

"(2) RULES OF CONSTRUCTION.—

"(A) IN GENERAL.—With respect to subclauses (I) and (II) of section 705(a)(2)(B)(i) (relating to a program of insured loans for training in the health professions), the requirements in such subclauses regarding accredited internship or residency programs are subject to paragraph (1) of this subsection.

"(B) EXCEPTIONS.—This section shall not—

"(i) prevent any health care entity from voluntarily electing to be trained, to train, or to arrange for training in the performance of, to perform, or to make referrals for induced abortions; or

"(ii) prevent an accrediting agency or a Federal, State or local government from establishing standards of medical competency applicable only to those individuals who have voluntarily elected to perform abortions.

"(c) DEFINITIONS.—For purposes of this section:

"(1) The term 'financial assistance', with respect to a government program, includes governmental payments provided as reimbursement for carrying out health-related activities.

"(2) The term 'health care entity' includes an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions.

"(3) The term 'postgraduate physician training program' includes a residency training program.".

Mr. COATS. Mr. President, let me just state, during our discussion last Thursday on this amendment, which I will describe in a moment, questions were raised by the Senator from Maine relative to some language and the interpretation of that language as it affected a portion of the bill providing for an exemption to the accreditation standards based on a conscience or moral clause relative to performing abortion.

We have discussed that question over the weekend and made some clarifications in that language, which is the purpose of the modification. The Senator from Maine spoke this morning and the Senator from Tennessee spoke, relative to the procedures of the Accrediting Council for Graduate Medical Education, its involvement in accrediting medical providers and medical training programs, and support for the Coats amendment to this particular bill.

Let me describe that very briefly. The problem that we had here is that, prior to 1996, the ACGME, which is the American Council on Graduate Medical Education, did not require hospitals or ob/gyn residency programs to perform induced abortions or train to perform induced abortions. That was done on a voluntary basis. Until 1996, hospitals were only required to train residents to manage medical and surgical complications of pregnancy, that is those situations where treatment of life-threatening conditions to the mother or complications of a spontaneous abortion, miscarriage, or stillbirth, was part of the medical training.

At the same time, 43 States have had in place statutes, as well as the Federal Government, to protect individual residents in hospitals from having to perform on a mandatory basis, or having to train on a mandatory basis, for the performance of induced abortions or abortion on demand. These procedures generally apply regardless of the reason to refuse to perform an abortion.

Then in 1996, the Accrediting Council on Graduate Medical Education changed its standards, indicating that failure to provide training for induced abortions could lead to loss of accreditation for these hospitals and for these training programs.

The reason this is important is that a great deal of Federal funding is tied to this accreditation. The Medicare reimbursement is tied to accreditation, loan deferral provisions are tied to accreditation, and a number of other federally provided support for hospital providers and for training programs for ob/gyn and others are tied to the accreditation. So, if the accreditation is removed, these institutions could lose their Federal funds.

So the language that I offered in the bill that we offered to the Senate basically said that, one, we do not think it is 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. For some it would be religious reasons; for some it would be moral reasons; for some it could be practical reasons; for some hospitals it could be economic reasons. There are a whole range of reasons why a provider may choose not to engage in this mandatory practice.

But at the same time, we did not feel that it was proper for us to mandate to a private, although somewhat quasi-

public, accrediting agency how they determine their accrediting standards. We do not want to prevent ACGME from changing its standards. It has every right, even though I do not agree with all of its requirements, to set its own standards.

Second, we do not want to prevent those who voluntarily elect to perform abortions from doing so. Nobody is prevented in this legislation from voluntarily receiving abortion training or from voluntarily offering that training in their hospital, nor do we prevent the Government from relying on those accreditation standards. I think you can make a case that the Government, by relying on a quasi-public entity for accreditation, may be too narrowly restricting in scope in terms of determination on Federal reimbursement, but we are not addressing that issue.

So this legislation does not prevent the Government from relying on the ACGME for accreditation. We do not prevent the Government from requiring training of those who voluntarily elect to perform abortions.

What we do do is attempt to protect the civil rights of those who feel that they do not want to participate in mandatory abortion training or performance of abortions. That is a civil right that I think deserves to be provided and is provided in this legislation.

It is a fundamental civil right, as a matter of conscience, as a matter of moral determination, as a matter of any other determination, as to whether or not this procedure, which is controversial to say the least, ought to be mandated and whether that is a proper procedure for those who then are forced to participate in programs in order to receive reimbursement from the Federal Government for various forms of support. We do not believe that it is.

There was some question about the so-called conscience and morals clause that was included in the accrediting standards, but we had testimony before our committee from a number of individuals who felt that that exception language was unnecessarily restrictive for those who felt, because they were a secular hospital or because they were residents in a training program at a secular hospital, that conscience-clause exception would not protect them from the loss of accreditation or protect their basic civil rights.

I have just some examples of that. The University of Texas Medical Branch at Galveston wrote to us essentially saying, and I quote:

> Those involved in resident education at the University of Texas Medical Branch made a decision in the mid 1970's not to teach elective abortion as part of our curriculum. This decision was based, originally, on concerns other than moral issues. We encountered two significant problems with our Pregnancy Interruption Clinic, or PIC as it was known at the time. First, the PIC was a money loser. Since there was no reimbursement for elective abortions from either State funds or Medicaid a great deal of expense of the PIC was underwritten by faculty professional income. Faculty income was used without regard to the moral concerns of individual faculty members who generated the income. A second problem was more significant and involved faculty, resident, and staff morale. Individuals morally opposed to performing elective abortions were not required to participate. This led to a perception, by trainees performing abortions, that they were carrying a heavier clinical load than trainees not performing abortions. As fewer and fewer residents choose to become involved in the PIC, this perceived maldistribution of work became a significant morale issue. Morale problems also spilled over to nursing and clerical personnel with strong feelings about the PIC. It is a gross understatement to say that elective abortion is intensely polarizing. Because of bad feelings engendered by a program that was a financial drain, the PIC was closed.

So here is a respected hospital, the University of Texas at Galveston, which basically said the moral, conscience reasons were not basically the reasons why this particular hospital chose not to participate in the program.

They followed that up with a letter, which I will quote again. They said:

> Because we are a secular institution, and a state supported university, we would have no recourse under the new ACGME "conscious clause," except to provide such instruction to our trainees. The ACGME "conscious clause," providing an opportunity to invoke a moral exemption to teaching elective abortion, is restricted to institutions with moral or religious prohibitions on abortion. It does nothing to protect the faculty at State-run universities.

I have a similar letter from Mt. Sinai Hospital:

> Your amendment is desperately needed to protect the rights of faculty, students and residents who have no desire to participate in abortion training but who do not work in religious or public hospitals.
>
> Since our institution would not, therefore, "qualify" as one with a moral or legal objection—

Therefore, the moral and conscience clause would not protect them.

Albany Medical Center in New York offers the same, and the list could go on and on.

So, essentially, what we are saying here is that the amendment that I am offering is clearly one which is designed to protect the basic civil rights of providers and medical students in training who elect, for whatever reason, whether it is a moral or conscience reason or whether it is an economic, social or other reason, not to perform abortions.

We do not believe that it is proper for the Federal Government to deny funds on the basis of lack of accreditation if that lack of accreditation is based on the decision of a provider or a program that they do not want to participate in a mandatory training procedure for induced abortions.

I am pleased we were able to work out language with the Senator from Maine, which addressed her concerns to make sure that we did not prohibit ACGME from accrediting or not accrediting, because there are other reasons why facilities might not deserve accreditation. Federal funds certainly should not flow to those hospitals and to those programs that do not meet up to basic medical standards that the Government requires for its reimbursement.

By the same token, we do not think that injecting a forced or mandatory induced abortion procedure on these institutions, for whatever reason, is appropriate. That is the basis of the amendment. The amendment has now been offered. It has the support of the Senator from Maine.

The Senator from Tennessee, Dr. FRIST, spoke this morning. He certainly knows more about these procedures and more about the medical concerns than this Senator from Indiana. He has looked this bill over very, very carefully and believes that the language incorporated in the Coats amendment is most appropriate, and he is supportive of that. I think that is a solid endorsement from someone who clearly understands the issue in great depth and understands the accrediting process, supports that process, but believes there ought to be this exemption.

Mr. President, I have not yet asked for the yeas and nays on this. My understanding is that the vote will be ordered, along with other votes, after 2 p.m. So I will now ask for the yeas and nays for this amendment.

The PRESIDING OFFICER (Mr. SMITH). Is there a sufficient second? There appears to be a sufficient second. There is a sufficient second.

The yeas and nays were ordered.

Mr. COATS. Mr. President, I yield the floor.

The PRESIDING OFFICER. The time of the Senator from Indiana has expired.

Mrs. BOXER addressed the Chair.

The PRESIDING OFFICER. The Senator from California is recognized for 15 minutes.

Mrs. BOXER. I wanted to clarify that. I know we lost some time here. So I have 15 minutes remaining to discuss both amendments, is that correct, Mr. President?

The PRESIDING OFFICER. The Senator is correct.

Mrs. BOXER. Thank you very much, Mr. President.

I want to explain why it was that it took the Senate extra time to get to this point of debating these amendments. The modified amendment came to the attention of my staff, in its final form, late last night. I was on a plane coming back from California, where I had a full schedule. When I returned at midnight, clearly, it was too late to contact my colleagues, and, therefore, I needed some time to really read the amendment and understand its implications, because the amendment, as modified, is of grave concern to me.

The longer I have to look at this amendment, the more concerned I am about it. I would like to explain to my colleagues why. Before I do that, I want to explain also that those in this

community who support a woman's right to choose strongly oppose the Coats amendment. Those groups—who oppose this amendment are the Women's Legal Defense Fund, the National Abortion Federation; the American Association of University Women; the National Women's Law Center; Planned Parenthood, and the National Abortion Reproductive Rights Action League.

I think it is very, very clear why. It is because if you look at what could happen as a result of the Coats amendment, you quickly come to the conclusion, Mr. President, that theoretically—and we hope it would not happen—but it is possible under this amendment that every single medical school in this country could stop teaching their residents how to perform safe, legal abortions and still get Federal funding.

I really do feel that is the intent because I know there are those in this Senate, and I have great respect for them, who would like to outlaw a woman's right to choose. They cannot do it up front, so they try to do it in every which way they can. This is just one more example like they said, if the woman is in the military she cannot get a safe abortion in a military hospital. This is the kind of theory that you see being practiced on the floor. I say to my friends, they have every right to do this. I respect their right to do it. But I strongly disagree.

Under current circumstances, for a medical school with an ob/gyn Residency training program to get Federal funds they must teach their residents how to perform safe, legal abortions unless the institution has a religious or moral objection, called a conscience clause. I fully support that conscience clause. I do not believe that any institution that has a religious or moral problem should have to teach their residents how to perform safe, legal abortions. However, under this modified amendment by Senator COATS, any institution can stop teaching abortion and still get the Federal funds even if they have no religious or moral objection.

For example, let us suppose the anti-choice community targets a particular hospital or medical school and day after day stands outside there protesting and demanding that they stop, and finally the institution throws up its hands and says, "You know, it isn't worth it. We will still get our Federal funds. We'll just stop teaching how to perform safe, legal abortions."

What does that mean? It seems to me that as long as abortion is legal in this country—and it is legal under Roe versus Wade, and it has been upheld to be legal by the Court—what we are doing here is very dangerous to women's lives, because if we do not have physicians who know how to perform these safe abortions, we are going to go back to the days of the back alley.

My friends, I have lived through those years, and no matter how many people think you can outlaw a woman's right to choose, in essence, even when abortions were illegal in this country, they happened. They happened in back alleys. They happened with hangers. Women bled to death and women died. We need doctors to know how to perform safe, legal abortions. It is very, very important.

What if a woman is raped? What if she is a victim of incest, and she is in an emergency circumstance, and they cannot find a doctor who knows how to do a safe, legal abortion? That is the ultimate result of this. That is why so many organizations who care about women, in my opinion, are opposing this amendment.

We need trained and competent people to take care of the women of this country. If they have a religious or moral problem, I strongly support their right not to have to learn how to perform such an abortion. But if they have no conscience problem, if the institution has no conscience problem, it is in the best interests of all of us that we have doctors who are trained, competently, to perform surgical abortions until there is another way for a woman to exercise her right to choose that is safe.

I ask the Chair, how much time do I have remaining?

The PRESIDING OFFICER. The Senator has 9 minutes, 45 seconds remaining.

Mrs. BOXER. I ask that the President advise me when I have 5 minutes remaining. I will retain those 5 minutes.

AMENDMENT NO. 3508

Mrs. BOXER. Mr. President, I have an amendment that I ask for the yeas and nays on right now, if I might, dealing with the District of Columbia. I ask for the yeas and nays on that amendment.

The PRESIDING OFFICER. Is there a sufficient second? There appears to be a sufficient second. There is a sufficient second.

The yeas and nays were ordered.

(Mr. COATS assumed the chair.)

Mrs. BOXER. I want to thank my colleague for allowing me to have an up-or-down vote. It is quite simple. Mr. President, in this country called America, there are 3,049 counties and 19,100 cities. It seems to me extraordinary that in this bill that is before us, there is only one entity that is singled out and only one entity that is told that it cannot use its locally raised funds to help a poor woman obtain an abortion.

We already have strict control on the use of Federal funds. No Federal Medicaid funds may be used by any city, county, State or entity for abortion. But we have no stricture on what a local government can do, except in this bill where we tell Washington, DC, they cannot use their own property taxes to help such a poor woman, they cannot use fines they collected to help such a poor woman. I think it is a rather sad situation.

I know my colleagues will get up here and say, "We think we can tell Washington, DC, to do whatever we want it to do." If we want to do that with Federal funds, that certainly is an argument, but not with their own locally raised funds.

So, Mr. President, what I simply do by my amendment, by adding the word "Federal" my amendment clarifies a point. My amendment guarantees that Washington, DC, will be treated as every other city and every other county in this country. They may not use Federal funds—although, by the way, I object to that, but I know I do not have the votes to overturn that situation—but I am hoping that we can get the votes to stand up and say that local people can decide these matters on their own.

What always interests me in this Republican Congress is, we hear speech after speech about "Let the local people decide, let the States decide. Why should Big Brother come into cities and localities and States and decide for them?" Yet, when it comes to this issue, somehow this philosophy goes flying out the window and we are going to tell a local elected body how they should treat the poor women in their community.

Now, a woman's right to choose is the law of the land. But if she is destitute and she is in trouble, it is very hard for her to exercise that legal right. And if the locality of Washington, DC, wants to help her, I do not think we should stop them.

Thank you, very much. I reserve the remainder of my time.

Mrs. MURRAY. Mr. President, I rise in strong support of the amendment offered by my colleague from California, Senator BOXER. I am proud to be a cosponsor of this measure and I urge all of my colleagues to do the right thing and vote for our amendment.

Since 1980, Congress has prohibited the use of Federal funds appropriated to the District of Columbia for abortion services for low-income women, with the exception for cases of rape, incest, and life endangerment.

From 1988 to 1993 Congress also prohibited the District from using its own locally raised revenues to provide abortion services to its residents. I am pleased that for fiscal year 1994 and 1995 Congress voted to lift the unfair restriction on the use of locally raised revenues, and allow the District to decide how to spend its own locally raised moneys.

There is language in this bill that would coerce the District into returning to the pre-1994 restrictions. This bill is a step backward, and we shouldn't allow it to pass. Congress does not restrict the use of dollars raised by the State of Washington or by New York, Texas, California or any other State—because Congress does not appropriate those funds.

Why should our Nation's capital be the solitary exception? It shouldn't be the exception, Mr. President, and our amendment ensures the District of Columbia will have the same rights as

every locality—every county and city—to determine how to spend locally-raised revenue.

I know why the District is being targeted in this way. And so does every woman, and so should every American. This is just another of the many attempts by some Members of Congress to chip away and take away a woman's right to choose.

It sure is ironic. That in this Congress, where the mantra has been "States know best" month after month, the majority party now wants to micro manage DC's financial decisions.

Mr. President, restricting the ability of the District to determine how it is going to spend its locally raised revenue is the "Congress knows best" approach at its worst. I find it so very hypocritical that virtually every debate over the past year has touted local flexibility and vilified Washington, DC's presence in policy making.

We should allow the District the same right as all other localities—to choose how to use their locally raised revenue. We should not single out our Nation's capital. We should pass the Boxer amendment.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The Chair informs the Senator the time will be charged to the Senator unless she asks unanimous consent that her remaining time be reserved.

Mrs. BOXER. I make a unanimous-consent request that my remaining time be reserved.

The PRESIDING OFFICER. The Senator has 6 minutes 6 seconds remaining, and that time will be reserved.

The quorum call will be charged to no one at this particular point.

The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. SPECTER. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SPECTER. Mr. President, I have sought recognition for a few moments this morning to speak in morning business for a period not to exceed 5 minutes. I ask unanimous consent that I may be permitted to do that.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator is recognized to speak up to 5 minutes.

Mr. SPECTER. I thank the Chair.

(The remarks of Mr. SPECTER pertaining to the introduction of legislation are located in today's RECORD under "Statements on Introduced Bills and Joint Resolutions.")

Mr. SPECTER. Mr. President, before yielding the floor, I have been asked to take a limited leadership role here.

PROVIDING FOR THE EXCHANGE OF LANDS WITHIN ADMIRALTY ISLAND NATIONAL MONUMENT

Mr. SPECTER. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 213, H.R. 1266.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

A bill (H.R. 1266) to provide for the exchange of lands within Admiralty Island National Monument, and for other purposes.

The PRESIDING OFFICER. Is there objection to the immediate consideration of the bill?

There being no objection, the Senate proceeded to consider the bill.

Mr. MURKOWSKI. Mr. President, I rise to join with the senior Senator from Alaska to urge my colleagues to support H.R. 1266.

This bill ratifies a land exchange agreement in Alaska between the Forest Service and the Kennecott Greens Creek Mining Co. The agreement will help provide 300 jobs in Alaska, promote sound economic and environmentally responsible resource development, and further the interest of land consolidation on conservation systems in the Tongass National Forest.

Mr. President, this bill has bipartisan support. Chairman DON YOUNG was the author of the bill in the House and as a result of his efforts, the bill passed the House of Representatives with support from the ranking member of the Resource Committee. Chairman DON YOUNG deserves credit for his hard work on this bill.

In the Senate, the Greens Creek Land Exchange was reported out the Energy and Natural Resources Committee by unanimous consent. The bill is supported by the Forest Service and local environmental organizations.

Mr. President, let me explain the history of the Greens Creek Mine and this agreement. The Greens Creek Mine was located under the mining laws while the area was still part of the general National Forest area. As you may know, in 1980 the area became part of the Admiralty Island National Monument through the enactment of the Alaska National Interest Lands Conservation Act [ANILCA]. Because this mine had world-class potential, Congress made special provisions in the act to ensure that the mine could go forward.

I was pleased to participate in the opening ceremonies of the Greens Creek Mine. The mine provided high-paying jobs to Juneau residents and supported the local economy. Unfortunately, low metal prices caused the temporary closure of the mine in April 1993. Kennecott worked diligently to reorient its mining development plan to permit the mine to reopen. In fact, they recently announced plans to reopen the mine during the next several months.

Mr. President, this land exchange is the combination is a 10-year effort by Kennecott to deal with one of the problems created by the special management regime in ANILCA. Although that regime permitted the perfection and patenting of certain claims, it did not provide an adequate time for exploration of all the area of mineral potential surrounding the Greems Creek Mine.

Sinoe Kennecott determined that it would be unable to fully explore all the areas of interest during the 5-year time period it was allowed to provide exploration under ANILCA, it has been searching for a way to explore these areas.

They have engaged in a multiyear negotiation with the Forest Service to develop a land exchange which would permit access to the area in a manner which is compatible with the monument designation provided by Congress in 1980.

In other words, the land exchange allows exploration under strict environmental regulations. The terms of the exchange require Kennecott to utilize its existing facilities to the maximum extend possible to ensure minimal changes to the existing footprint.

Additionally, the development of any areas once explored would be under the same management regime by which Kennecott developed the existing Greens Creek Mine.

This land exchange also provides other major benefits to the Government, the community, and the environment.

At the end of mining, Kennecott will revert its existing patented claims and any other claims which it holds on Admiralty Island to the Federal Government.

Kennecott will also fund the acquisition of over 1 million dollars' worth of inholdings in the Admiralty Island National Monument and other conservation system units in the Tongass.

Finally, the exchange improves the likelihood that 300 jobs will return to the Juneau area for many years to come.

Mr. President, the Greens Creek Land Exchange is good policy. I congratulate Kennecott and the Forest Service for negotiating a fair agreement and urge the President to sign the bill as soon as possible.

Mr. SPECTER. Mr. President, I ask unanimous consent that the bill be deemed read a third time, passed, the motion to reconsider be laid upon the table, and that any statements relating to the bill be placed at the appropriate place in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

So the bill (H.R. 1266) was considered and passed.

Mr. SPECTER. Mr. President, I make the request of the clerk, who is asking me to do that on behalf of leadership, to discount any personalized knowledge as to the complexities which we have ruled upon.

I have been asked to further make this request for unanimous consent.

AMENDING THE FEDERAL FOOD, DRUG, AND COSMETIC ACT

Mr. SPECTER. Mr. President, I ask unanimous consent that the Labor

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Committee be discharged from further consideration of H.R. 1787, and, further, that the Senate proceed to its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The assistant legislative clerk read as follows:

A bill (H.R. 1787) to amend the Federal Food, Drug, and Cosmetic Act to repeal the Saccharin notice requirement.

The PRESIDING OFFICER. Is there objection to the immediate consideration of the bill?

There being no objection, the Senate proceeded to consider the bill.

Mr. SPECTER. Mr. President, I ask unanimous consent that the bill be deemed read a third time, passed, the motion to reconsider be laid upon the table, and that any statements relating to the bill be placed at the appropriate place in the RECORD.

Again, I make a disclaimer, Mr. President, that I am making this statement at the request of the clerk in the absence of leadership where more detailed knowledge is present as to the specifics involved.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator's reservation is duly noted.

So the bill (H.R. 1787) was considered and passed.

Mr. SPECTER. I thank the Chair.

In the absence of any other Senator on the floor, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will oall the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. KENNEDY. Mr. President, I ask unanimous oonsent that the order for the quorum oall be rescinded.

The PRESIDING OFFICER (Mr. SMITH). Without objection, it is so ordered.

BALANCED BUDGET DOWNPAYMENT ACT, II

The Senate continued with the consideration of the bill.

Mr. KENNEDY. Mr. President, I understand the time is controlled. I yield myself 12 minutes from Senator BOXER.

The PRESIDING OFFICER. The Senator from California has 5 minutes remaining. Senator MURRAY has 7½, and Senator FEINSTEIN has 7½.

Mr. KENNEDY. I yield myself 3 minutes, Mr. President.

The PRESIDING OFFICER. Without objeotion, it is so ordered.

AMENDMENT NO. 3508

Mr. KENNEDY. Mr. President, very briefly, there are two major proposals before the Senate this afternoon. One proposal prohibits the Distriot of Columbia from using locally raised funds to provide abortions for its residents. It allows the Congress of the United States to undermine the constitutional rights of poor women and thus, their ability to receive an abortion.

We do not interfere with the disbursement of local funds in any of the States beoause it is inappropriate to dictate State and local policy in this area. It is equally inappropriate to impose the will of the Federal Government on the District of Columbia. This is the long arm of the Federal Government reaching in and dictating the health conditions for needy women in the District. Many of these women have determined that they must have an abortion but, because they are poor, they need assistance from the District of Columbia. Distriot of Columbia elected officials should have the ability to allocate funds to women in these circumstances.

Second, I reject the belief that the Senate should determine medical residency training criteria as it pertains to issues regarding women. This is the first real attempt to superimpose Congress' view on obstetrio and gynecological medical training. Today, we are saying we will not requlre that medical training institutions provide abortion training for ob/gyn residents. Tomorrow, we may be making policy and setting standards in another area of medical training. Congress should leave ths practice of medicine to the doctors. In this case, a highly respected board is attempting to insure that we have the best-trained physioians in the world. We have already acceded to a oonscience clause that protects religious and moral beliefs of institutions and residents. Those individuals and institutions will not be required to participate in certain medical procedures that violate their oonscienoe or their religious training. But to go beyond that by passing a law that substitutes congressional and political opinion for medical decisionmaking is wrong. Congress should not interfere with current ACGME polioy. It is an inappropriate use of our authority. It is bad policy and it is bad medicine. We should reject this proposal.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. KENNEDY. Mr. President, I yield whatever time remains.

Mrs. BOXER addressed the Chair.

The PRESIDING OFFICER. The Senator from California.

Mrs. BOXER. I yield myself 1 minute just to say to the Senator from Massachusetts how grateful I am that he expressed his views on the floor. This has been a very difficult morning beoause there was a modified amendment which, unfortunately, I could not get to analyze until this morning. And the Senator is right. We already have a conscience olause. Any institution who has a moral or religious objection to teaching abortion is covered under current law, and what this would say is that any institution, even if they did not have a moral or religious objoction, would not have to teach residents how to perform safe, eompetent abortions so that our women are safe.

On the matter of Washington, DC, I wish to tell the Senator that there are 3,049 counties, 19,100 cities, and every one of them has the right to spend their locally raised funds as they wish. To pick out one entity and reach the long arm of the Federal Government into it is really unfair and goes against the supposed spirit of this Republioan Congress. So I thank my friend very muoh.

The PRESIDING OFFICER. The Senator has used her 1 minute.

Who yields time?

Ms. SNOWE addressed the Chair.

The PRESIDING OFFICER. The Senator from Maine.

Ms. SNOWE. I thank the Chair.

The PRESIDING OFFICER. The Senator from Maine has 30 minutes allocated to her under the previous order.

AMENDMENT NO. 3513, AS MODIFIED

Ms. SNOWE. I will consume as much time as I require. I thank the Chair.

I rise today to join the distinguished Senator from Indiana in offering an amendment that I think will address many concerns. In fact, I am pleased to have the opportunity to clarify some of the misinformation that has been expressed regarding this compromise amendment.

No one can question whether or not it is appropriate to ensure quality care for women in America. No one can question that we need to maintain aoreditation standards for medical institutions across this country. The fact remains that this amendment on which I worked in conjunction with the Senator from Indiana does not allow Federal funds to go to an unacoredited institution because they fail to provide for abortion training.

Nothing oould be further from the truth. This amendment accomplishes two things. One, it does protect those institutions and those individuals who do not want to get involved in the performance or training of abortion when it is contrary to their beliefs. Second, and just as important, it preserves the quality of health care that will be provided to women because it protects the universally accepted standards—there is only one set of standards—of the Accreditation Counoil for Graduate Medical Education that provides for quality standards for ob-gyn programs. So this amendment would not only make sure that women have access to quality health care with the strictest of standards when it comes to quality and safety but it also will ensure that they have acoess to physicians who specialize in women's health care.

I do not think anybody would disagree with the fact—and I am prochoice on this matter, but I do not think anybody would disagree with the fact that an institution or an individual who does not want to perform an abortion should do so oontrary to their beliefs. But at the same time we have to make sure we preserve the accreditation standards that are established by the Accreditation Council for Graduate Medical Eduoation, that provides for the standards for more than 7,400 medical institutions in America.

We want to make sure we do not undo 50 State licensure boards with respect to overturning or overriding this one set of accreditation standards. That is what we were dealing with, and hence this compromise here today, because whether we like it or not—and certainly I do not like it—in the House of Representatives they have already passed legislation that would allow Federal funds to go to an unaccredited institution. That is a fact, and that is unacceptable. That is why I worked with the Senator from Indiana to ensure that would not happen.

Contrary to what has been said here today, 88 percent of medical institutions in this country do not provide abortion training even though it is implicitly required in the accreditation standards. So we are not broadening this issue to provide for an exodus from performing or participating in abortion training. Eighty-eight percent of the institutions ourrently do not provide it, even though there is a conscience olause.

So this legislation is saying we do not want what is going to happen in the House of Representatives with the accreditation standards being dismissed and abandoned. That is an issue and that is a reality. That is why I worked with the Senator from Indiana to ensure that we preserve ths one set of standards in America that the Federal Government relies on for the purposes of Federal funding, that medical students rely on for the purposes of Federal funding, that physicians rely on in terms of judging standards, that patients and consumers and States rely on in terms of determining their licensing procedures.

So the ohoice was not to address the reality of what is taking place in the House or making sure, more importantly, that the Senate was on record in opposition to that kind of language and developing a compromise with the Senator from Indiana to ensure that we maintained the accreditation standards for all medical institutions to advance the quality health care for women and at the same time to allow tralning for abortion for those who want to participate in that training or for the institutions who want to provide it. Because that is the way it is done now. That ie the status quo, and that 1s not changing.

I know consensus and compromise is not the norm anymore. I think it is important on this issue because abortion is a very divisive issue. No one can challenge me on where I stand oh this issue. But I think it is also important to make sure that we preserve quality health care for women in America. I do not want to see these accreditation standards undone, and that is what the legislation that was originally pending would have done. The House language went much further than that. This is a compromise to preserve those standards. This is a compromise to ensure that it does not jeopardize the 273 ob-gyn programs that otherwise would have been affected if this compromise was not before us. That is the risk, and that is why I worked with the Senator from Indiana to ensure that would not happen.

It is inappropriate for this institution to be involved in the accreditation standards or curriculum, but that is not what we are dealing with here. It has already happened. I want to be able to go to oonference to ensure that the House language is not adopted, and the hest way to do that is to ensure we can pass language that everybody could agree on, that represents a consensus and does not jeopardize the kind of oare that women in America deserve. That is what this compromise amendment is all about.

I urge adoption of this compromise amendment. To do otherwise is to risk getting the House language in the final analysis. That, indeed, would set a very dangerous precedent.

Mr. President, I yield 5 minutes to the Senator from Indiana.

The PRESIDING OFFICER. The Senator from Indiana is recognized for 5 minutes.

Mr. COATS. Mr. President, I thank the Senator from Maine for her diligent work with us in clarifying language here and for her articulate statement of support and the reasons why she supports this particular amendment. I will not repeat those, but I think they clearly make the case.

I would like to respond, also, to the Senator from California, who indicated that one of the reasons why she opposes the Coats amendment is that we will not have medical personnel adequately trained to perform abortions if necessary.

I would like to state for the record that an ACGME member—the certifying body—ACGME member submitted testimony to the Senate Labor and Human Resources Committee that the D&C procedures that are taught to every ob-gyn and procedures used in cases of miscarriages and those of induced abortion require similar experience. Numerous ob-gyn's have indicated to us—and I have a pile of letters here from them, indicating so, and I will be happy to submit those for the RECORD—that an OB-GYN who is trained, as they must be trained, to perform D&C procedures in the case of spontaneous abortions, are more than adequately prepared, should the need arise, to perform an induced abortion. Again, I have an extensive set of letters from those who are trained in those procedures, indicating that is the case.

In short, a resident needs not to have performed an abortion on a live, unborn child, to have mastered the procedure to protect the health of the mother if necessary. Maternal health will not be improved by forcing ob-gyn's to perform abortions on live fetusee if an ob-gyn will not do an abortion in actual practice. But it is clear from the record that they will have sufficient training to do so if necessary.

Second, I would like to just once again, for my colleagues' benefit, indicate the support of Dr. BILL FRIST, the Senator from Tennessee, for this amendment, who has stated, "The Coats amendment will protect medioal residents, individual physicians, and medical training programs from abortion-related discrimination in the training and licensing of physicians." "However," he goes on to say, "in our efforts to safeguard freedom of conscience, there are limits to what Congress can impose on private medical accrediting bodies. I believe this amendment stays within the confines of the governmental role and addresses the matter of discrimination in a way that is acceptable to all parties. The Congress is responsible," he goes on to say, "for the Federal funding that is tied to acoreditation by the ACGME, and as publio servants we must ensure that there is no hint of discrimination associated with the use of public funds, and that is exactly what this amendment does."

AMENDMENT NO. 3508

I would like to respond to the issue raised in the second amendment, the amendment offered by the Senator from California, relative to the use of funds for abortions in the District of Columbia. It is clear, as the Constitution so states, that article I, section 8, gives this Congress exclusive legislation over all cases whatsoever in the Distriot of Columbia. It is stated in the Constitution clearly. It has been the basis on which we have operated, and it is a constitutional basis. In all matters relative to the District of Columbia, the responsibility for proteotion of those and implementation of those and establishment of those is established in the Constitution of the United States.

Public law 931-98, the home rule law, is consistent with this constitutional mandate, because it charges Congress with the responsibility for the appropriation of all funds for our Nation's Capital. The Congress, then, bears the ultimate constitutional and full responsibility for the District's abortion policies.

Second is the question of eeparating or mingling.

I ask the Senator from Maine if I could have an additional 2 minutes from her time?

Ms. SNOWE. Mr. President, how much time do I have left?

The PRESIDING OFFICER. The Senator from Maine has 17 minutes remaining.

Ms. SNOWE. Yes, I yield the Senator 2 additional minutes.

Mr. COATS. Second, let me state this idea of separating Federal from District funds is nothing more than a bookkeeping exercise. Essentially, what would happen is that the so-called District funds would allow the local government to continue funding abortion on demand. I do not believe that is something this Congress endorses. I do not believe that is something that we should not deal with as

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we have dealt before. The separation of Federal funds from District funds is a distinction without a difference, given the constitutional mandate and the practice of this Congress to appropriate all funds for expenditure in the District. We all know that the District has one of the more permissive, if not one of the most permissive abortion funding policies in the country. It is essentially unrestricted abortion on demand. I do not believe that is what this Congress wants to authorize for the District of Columbia, and we have, on numerous instances, addressed this issue.

In the conferenoe report that is before us on the omnibus funding bill, this was discussed at length. The language that is incorporated is language that has been agreed to by the conferees. It does allow the use of funds for abortions to protect the life of the mother or in cases of rape or incest. Members need to understand that. What we are not trying to do, what we are opposing, what I am opposing and others are opposing, is the use of those funds for unrestricted abortion, abortion on demand. That is the issue before us on the Boxer amendment, and I urge my colleagues to vote no on that and vote yes for the Coats amendment, which is a separate issue, and that is the discrimination issue relative to the use of Federal funds for hospitals that provids abortion.

I yield.

Mrs. BOXER addressed the Chair.

The PRESIDING OFFICER (Mr. CAMPBELL). The Senator from California [Mrs. BOXER] is reoognized.

Mrs. BOXER. Mr. President, Senator FEINSTEIN offered me her time. I ask unanimous consent that I be allowed to use her time.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. BOXER. I ask the President how much time Senator FEINSTEIN has.

The PRESIDING OFFICER. Senator FEINSTEIN has 7½ minutes.

Mrs. BOXER. And I believe I have a minute and some?

The PRESIDING OFFICER. The Senator from California has 1 minute 15 seconds.

Mrs. BOXER. Mr. President, will you let me know when I have 5 minutes remaining?

The PRESIDING OFFICER. Yes, the Chair will.

Mrs. BOXER. Thank you very much, Mr. President. I want to respond to Senator COATS' point on the D.C. issue when he says, "Look, we still allow them to use their own local funds for rape and incest but not for abortion on demand, not for unrestricted abortion." I want to make this point because over and over again in this debate by the anti-choice Senators, they use the terms abortion on demand and unrestricted abortion. They use the terms and ignore the holding of Roe versus Wade.

Anyone who has read Roe versus Wade knows the anti-oholce Senators are not using the terms correctly. According to Roe, in the first 3 months of a woman's pregnancy, she has a right to ohoose. That is her legal right. The Supreme Court has decided it, and even in this more conservative Court, has reaffirmed it.

Clearly, a poor woman in Washington, DC, cannot get access to Medicaid funding, and the only option she would have, except for oharity, would be Washington, DC's own locally raised funds, Mr. President. We do not stop any one of the 3,000-plus counties in this country from using their local funds if they wish, if they desire to help a poor woman. We do not tell the 19,100 cities that they cannot use their locally raised funds.

Washington, DC, does have property tax funds, and they have other funds that clearly are raised by them. If they feel it is a priority to help a woman in poverty in a desperate situation exercise her right to choose, I do not think the long arm of U.S. Senators ought to reach into that situation. That ought to be her own private personal decision and the decision of the locality to help her out.

So I hope that there will be support for the Boxer amendment.

AMENDMENT NO. 3513

As to the Coats amendment regarding Federal funding to medical schools, I want to reiterate what I think is a very important point.

The Senator from Indiana says, "There is not going to be any danger, no one is going to be put in danger by this. So what if every single teaching hospital and medical school says, 'We will not teach our residents how to do surgical abortion.'" He says, "Oh, they will have enough training in emergency areas, D&C's, and other ways."

I do not think the Senator from Indiana would get up here and say it is not necessary for residents to learn how to do a bypass if it was their heart. "Oh, you can just learn it from reading a book, you can look at a computer simulation." No one would ever suggest that.

I really have to say, with due respect, total respect for my colleague, that we are treating women in this circumstance quite differently than a person who had a heart condition, than a person who needed a kidney operation. We would never stand up here and say that doctors do not have to be trained in actually doing those procedures.

Mr. COATS. Will the Senator yield on that point?

Mrs. BOXER. I will yield on the Senator's time, because I am running out of time. I will yield on Senator SNOWE's time.

The PRESIDING OFFICER. The Senator asked to be notified when she had 5 minutes remaining. She has 5 minutes.

Mrs. BOXER. Why do I not yield to the Senator on Senator SNOWE's time?

Mr. COATS. If that is appropriate with the Senator from Maine.

Mrs. BOXER. I retain my 5 minutes.

Ms. SNOWE. I yield 2 minutes.

Mr. COATS. Mr. President, I just want to inform the Senator from California and our colleagues that what I stated was that on the basis of letters that we have received from a number of trained physioians in obstetrics and gynecology that the similarities between the procedure which they are trained for, whioh is a D&C procedure, and the procedures for performing an abortion are essentially the same and, therefore, they have the expertise neoessary, as learned in those training procedures, should the occasion occur and an emergency occur to perform that abortion.

But to compare that with not having training for a bypass operation or kidney operation or anything else would not be an accurate comparison. There are enough similarities between the procedure they are trained for and the procedure the Senator from California is advocating they need to be trained for that is not a problem.

I ask unanimous oonsent to have printed in the RECORD, Mr. President, letters that I have received which so state that training is adequate.

There being no objection, the letters were ordered to be printed in the RECORD, as follows:

NATIONAL FEDERATION OF CATHOLIC PHYSICIANS' GUILDS,
Elm Grove, WI, March 23, 1995.

Re the amendment offered by Senator Coats to S. 555, Health Professions Education Consolidation and Reauthorization Act of 1995.

MEMBERS,
Senate Labor and Human Resources Committee, U.S. Senate, Washington, DC.

DEAR SENATOR: I am writing on behalf of the National Federation of Catholic Physicians' Guilds which is the Catholic medical association in the United States, representing physicians and physician's guilds from all over the U.S. I respectfully urge you to support Senator Coats' Amendment, specified in Sec. 407. Civil Rights for Health Care Providers.

Senator Coats' amendment is certainly accurate in finding the ACGME's revised regulations on Residency Training for Obstetrics and Gynecology a violation of the civil rights of individuals and institutions that are morally or conscientiously opposed to abortion. The revised regulations would require, under penalty of loss of accreditation, Catholic Ob-Gyn training programs, or any training program for that matter, to provide for training in the performance of induced abortion. As you probably know, Catholic moral teaching holds abortion to be a grave moral evil. What might not be as clear is the fact that not only may a Catholic not participate in the procurement of an abortion, they may also not cooperate in any way with the procurement of an abortion; not only may they not offer training in abortions, they may also not provide for the opportunity of training in abortions. Such cooperation would give the cooperator a share of the culpability. The ACGME's regulation would be coercion, an attempt, under severe penalty for failure to comply, to force the institution to participate in the performance of an activity whioh it, in conscience, considered evil. This would seem to be a clear violation of the civil rights of the individuals and institutions involved.

It is of significant note that the ACGME's regulation revision in this matter comes at a

time when fewer and fewer Ob-Gyn physicians will do abortions. Ob-Gyn training programs that require abortion training are also declining in number. Physicians do not want to be involved in this procedure. Why they do not want to be involved is understandable. The medical profession has always held the moral belief that it's charge is the care of the life of the human being. The Obstetrician has always been the doctor who takes care of the mother and the baby until the baby is born and the Pediatrician can take over the baby's care. It is not in the professional ethos, in the soul of the physician, to take life. It is his or her charge to protect it! Abortion is a surgical procedure that intentionally takes the life of the baby and exposes the mother to a normally unnecessary operation. All of this violates the moral basis of the physician's code. The physician cannot be cast as a killer. He or she is a healer and an agent of the patient for healing. If the regulation mandate from the ACGME is an attempt to require physicians to perform a morally reprehensible act to serve a political charge, then the ACGME has stepped well beyond it's reason for existence.

The stated premise behind the ACGME's revision of the standards was to "address the need for enhanced education in the provision of primary and preventative health care for women by obstetrician-gynecologists". (ACGME Press Release, 16 Feb. 95) How does abortion training enhance the provision of primary and preventative health care for women? Primary health care involves the prevention of pathology. Pregnancy is not a disease that must be treated by termination. Primary health care provides medical care for the mother and the child she is carrying. Primary care cares for the well-being of mother and child. To talk of abortion as primary care is a distortion of the meaning of care. We cannot define killing as care. Does abortion training enhance preventative health care for women? What does it prevent? Exposure to sexually transmitted diseases? No. Pregnancy? It certainly doesn't prevent pregnancy. The woman is already pregnant (which means she is already carrying a very dependent human life whom the Ob-Gyn is normally committed to care for, too, working to ensure the baby's successful entrance into the world). What does it prevent, then? Responsibility for my actions? Maternal love? Enhanced education in the provision of primary and preventative health care for women could cover a lot of territory. The destruction of one of the most natural functions of the human person; the characterization of pregnancy as a pathological condition; the denial of professional responsibility to two patients when the pregnant woman comes to your clinic; the acceptance of a cooperative role with the woman in the ending of her child's life . . . those do not seem to fit into this educational objective.

It must be noted that all Ob-Gyn physicians are trained to do D&C's and to handle fetal demise. The training in the specific procedure of induced abortion, especially considering the great moral questions involved, probably has no place as a requirement in Ob-Gyn training. If the ACGME believes it is responsible for providing physicians to do abortions, it needs to find a way to do it other than mandating that training programe include this procedure in their curricula.

Thank you for reading through a somewhat lengthy letter. The issue really is significant. It deals with a controversial area; a procedure that is legal to perform, but morally questionable and lamented by most Americans as an indication that something has failed. Also at stake are the civil rights of those who morally and religiously object to induced abortion and who are now being told that they must, under penalty, provide for training in abortion procedures. There is, as Senator Coats points out, the effect of "running out of business" training programs that could not obey the ACGME mandate. And, there is the chilling advocacy of the notion that the doctor should be killer.

I ask you, on behalf of the many members of the NFCPG, and other medical professional men and women of conscience who cannot obey this regulation, to support Senator Coats' amendment and keep true choice available to us.

God bless you in your many varied and difficult duties.

Sincerely,

KEVIN J. MURRELL, M.D.,
President.

THE UNIVERSITY OF
TEXAS MEDICAL BRANCH AT GALVESTON,
Galveston, TX, March 23, 1995.

VINCENT VENTIMIGLIA,
Office of Senator Dan Coats,
U.S. Senate, Washington, DC.

DEAR MR. VENTIMIGLIA: I am a Professor of Obstetrics and Gynecology at the University of Texas Medical Branch at Galveston. It has come to my attention that Senator Coats, during upcoming hearings to reauthorize the Health Professions Education Act, will make efforts to protect the rights of Obstetrics and Gynecology training programs who choose not to teach techniques of abortion for contraception. For this I am deeply grateful.

The Commission which accredits training programs for residents in Obstetrics and Gynecology has made significant changes in requirements for accreditation. In the near future, "hands on" experience with elective abortion will be a required component of an approved residency training program. Although an individual trainee may invoke moral grounds to excuse himself from participating, no approved program, or program director, may excuse themselves.

Requirements for an accredited residency training are ultimately approved by the AMA's Committee on Graduate Medical Education (ACGME), and are listed in the Essentials of an Approved Residency. Under the current Essentials of an Approved Residency, an approved program is required to teach its trainees about management of abortion related complications, and provide some exposure to the technique of abortion. Currently a program may fulfill this requirement by providing instruction to residents in the care of women with spontaneous incomplete abortions or missed abortions. Requirements that become effective January 1 1996 specifically require training in the performance of elective abortion as a contraception technique.

Those involved in resident education at the University of Texas Medical Branch made a decision in the mid 1970's not to teach elective abortion as part of our curriculum. This decision was based, originally, on concerns other than moral issues. We encountered two significant problems with our "Pregnancy Interruption Clinic," or the PIC as it was known at the time. First, the PIC was a money loser. Since there was no reimbursement for elective abortions from either state funds or Medicaid a great deal of the expense of the PIC was underwritten by faculty professional income. Faculty income was used without regard to the moral concerns of individual faculty members who generated the income. A second problem was more significant and involved faculty, resident, and staff morale. Individuals morally opposed to performing elective abortions were not required to participate. This led to a perception, by trainees performing abortions, that they were carrying a heavier clinical load than trainees not performing abortions. As fewer and fewer residents chose to become involved in the PIC, this perceived maldistribution of work became a significant morale issue. Morale problems also spilled over to nursing and clerical personnel with strong feelings about the PIC. It is a gross understatement to say that elective abortion is intensely polarizing. Because of bad feelings engendered by a program that was a financial drain, the PIC was closed.

Regardless of our reasons, the failure to teach the technique of elective abortion has never been a factor in the approval of our program by an accrediting agency. When the changes to the Essentials of an Approved Residency become effective next January, I will never be forced to participate in the performance of abortion; but I am distressed that, to keep my current job, I would be forced to cooperate in an educational mission that espouses these objectives. To me, a "non-combatant" working to advance amoral objectives bears significant culpability. How could a pro-life physician ever become a Program Director if required to teach this curriculum? How could any Catholic hospital support such a training curriculum, even if its trainees went elsewhere to obtain the skills? Shouldn't program directors have freedom of choice to decide if a morally controversial area is included in their program? Where does a pro life medical student obtain training in an abortion free environment?

Aside from my personal problems there are larger issues. Due to a number of forces, there recently has been a de facto segregation of the abortionist from the mainstream of practitioners of Obstetrics and Gynecology. The abortionist has become a specialist apart from the rest of us—they are practitioners of a peculiar paraspecialty. Trainees completing a residency program in Obstetrics and Gynecology recognize that the professional community considers the abortionist to be a physician on the fringe of respectability. In addition to this marginalization by the professional community, marketplace forces make a new practitioner avoid abortions. Patients do not tend to seek obstetric services from physicians heavily identified with abortion. Young physicians who start doing abortions soon have a medical practice which only does abortions. Residents, hoping to practice the breadth of our specialty, structure their new practices accordingly. Changing the Essentials of an Approved Residency is a deliberate attempt by those wishing to disseminate abortion services to try to reintroduce abortion into the "everyday practice" of our specialty. Their claim that unique technical skills are involved in performing elective abortions, that are different from technical skills involved in treating spontaneous abortions, is ridiculous and a clear attempt to mislead. The changes in training requirements were not made to serve an educational agenda—only a political agenda.

This change in the Essentials is coercive. It will make my participation in furthering an amoral educational objective a condition of employment. I currently have the right not to teach that which is morally repugnant. I hope my right can be protected.

Sincerely,

EDWARD V. HANNIGAN, M.D.,
Frances Eastland Connally Professor.

CONGRESS OF THE UNITED STATES,
Washington, DC, August 2, 1995.

DEAR COLLEAGUE: There is one thing that can be said with certainty about the abortion training mandate of the Accreditation Council for Graduate Medical Education: it has nothing to do with ensuring that medical residents receiving training will be better equipped to provide appropriate health care

to women and children. OB/Gyn residents already learn the techniques to handle pregnancy, miscarriages and complications from abortions and, in learning these, learn the medical techniques to handle those extremely rare situations in which an abortion is actually performed in response to a women's health emergency.

So, if the ACGME directive is not really about providing medically necessary training for medical residents, what is it about? Simply, to accomplish what 20 years of legalized abortion have failed to do: to make abortion a part of mainstream of medical care and force doctors and hospitals to do abortion as if a refusal on their part would constitute substandard medical practice. Can there be any doubt whatsoever that after they define abortion as a part of standard medical care for residents, they will move on to declare it standard care for every hospital? Can there be any doubt the directive that we would overturn is only the first step in a battle against every medical facility which would dare claim that abortion is not "health care," that it is no part of standard medical practice?

The way in which ACGME and their friends in the pro-abortion community are going about this is deeply disturbing. They are not merely forcing doctors and hospitals to adhere to a particular ideology, they are requiring them in the name of practicing good medicine—to actually kill defenseless, unborn human lives. It is not enough for them that medical residents are already learning the techniques that could be used in abortion, but learning these without using them to destroy live human beings. Abortion advocates are not satisfied unless these techniques are used to kill unless residents resistance in this killing is actually numbered.

This attempt to overturn the healing ethic that is the very lifeblood of medical residency programs and medicine itself must be rejected. I ask that all Members support the provision in the bill to overturn the ACGME's directive and to oppose any motion to strike it.

Sincerely,

TOM DELAY,
Majority Whip.
TOM A. COBURN, M.D.,
Member of Congress.

ST. JOHN HOSPITAL
AND MEDICAL CENTER,
Detroit, MI, March 27, 1995.

DAN COATS,
Russell Senate Office Building,
Washington, DC.

This is a letter of support for any legislation that would prevent a residency program from being forced to implement a special kind of training that would be against the ethical and moral teachings of the institution in which the residency program resides. Specifically, we decry the decision made by the ACGME to mandate induced abortion training in all residency programs. There are major flaws in the reasoning of the ACGME: 1) an assumption that somehow abortions are not being carried out because of lack of providers: there is certainly no evidence of this locally or nationwide; 2) failure of the ACGME to recognize the fact that training to perform an induced abortion is exactly the same training as to perform a uterine evacuation procedure in the context of a missed abortion; 3) assuming that OB/GYN residency graduates are not performing induced abortion because they don't know how to; clearly every graduating OB/GYN resident from any program in the United States has the capabilities of being able to perform induced abortions but chooses not to on the basis of conscience and possibly also for a concern for personal rather than because they don't know how to do it; 4) by coming out so strongly for induced abortion, the ACGME creates further polarization in the United States over a very inflammatory issue when further polarization is counterproductive, 5) failing to recognize the philosophical integrity of an institution by arbitrarily forcing health care providers or individuals to do something against their institutional ethics.

In conclusion, the directors of the St. John Hospital and Medical Center's OB/GYN residency program strongly support legislation preventing coercion of a residency program toward implementing an unnecessary training that is against any institution's ethical and moral philosophy and thereby only contributes to the further polarization of the abortion issue in the United States.

MICHAEL PRYSAK, Ph.D., M.D.,
Program Director
and Vice Chief of Obstetrics.

PROVIDENCE HOSPITAL AND
MEDICAL CENTERS,
Southfield, MI, March 29, 1995.

Hon. DAN COATS,
U.S. Senate, Russell Senate Office Building,
Washington, DC.

DEAR SENATOR COATS: I urge the Senate Labor and Human Resources Committee to adopt the amendment you offered to S. 555, Health Professional Education Consolidation and Reauthorization. This amendment would neither limit abortion services currently available in this country, nor would it prevent physicians from seeking the training they might choose in order to perform abortions. This amendment would not interfere with a woman's legal right to choose an abortion. This amendment is about the right of institutions to refuse participation or cooperation in procedures which directly violate their ethical codes.

The reason that our organization, Providence Hospital and Medical Centers, supports this is because:

As a Catholic institution, we hold that direct abortion is a grave evil. It is therefore not an optional procedure for us, since we are bounded by Catholic ethical standards of health care. Since Catholic teaching classifies the direct killing of innocent human life to be among the gravest forms of evil, cooperating with the new ACGME OB/GYN residency guidelines by sending our OB/GYN medical residents to other facilities for training in induced abortions may not be a moral option for us.

There are over 45 OB/GYN residency programs in Catholic hospitals, about a third of all OB/GYN residency programs in the United States. We cannot afford losing these programs. Trying to coerce health care facilities who are morally opposed to direct abortions into cooperating with the new ACGME guidelines will not resolve the issue of the dwindling number of physicians being willing to perform abortions in the United States. It will only exacerbate the situation.

How would mandating abortion training enhance the provision of primary and preventative health care for women? Primary health care involves the prevention of a pathology. Pregnancy is not a disease to be treated by termination. Furthermore, all OB/GYN medical residents are currently trained to do D&C's, to handle fetal demise, and are trained in techniques such as early induction of labor when the pregnancy constitutes a serious life-threatening condition for the mother.

Thank you for considering adoption of this amendment.

Sincerely,

SISTER JANE BURGER, D.C.,
Vice President—Mission/Ethics Services.

CHRISTIAN MEDICAL & DENTAL SOCIETY,
Richardson, TX, February 15, 1995.

CHRISTIAN DOCTORS PROTEST ABORTION
TRAINING MANDATE

DALLAS, TX.—The Christian Medical & Dental Society (CMDS) announced today that it is protesting a medical council's decision to mandate abortion training as politically induced, personally coercive and professionally unnecessary. The Council for Graduate Medical Education, which oversees physician training, announced yesterday that obstetrical residents must be taught how to do abortions.

Dr. David Stevens, executive director of the Dallas-based CMDS, said, "The Council is clearly out of touch with its constituency, the vast majority of whom oppose abortion on demand." He cited the results of an independent nationwide poll of obstetricians, conducted in 1994 by the PPS Medical Marketing Group in Fairfield, New Jersey, that revealed that over 59 percent of obstetricians disagreed with the statement that "every OB/GYN residency training program should be mandated to include elective abortion training."

Stevens says the Council's decision "is apparently induced by political pressure from pro-abortion groups who want to force their belief system on a medical community that has largely rejected abortion." Stevens said that "pro-abortion leaders are worried that few doctors are willing to perform abortions, based on personal convictions as well as the sheer repugnancy of the act itself."

Stevens said that despite the Council's technical allowances for moral or religious objections, the practical effect of the Council's ruling will be to pressure every resident and teaching hospital into performing abortions.

"Throwing in a little verbiage about 'moral or religious objections' does little to remove the intense pressure these residents will now face to perform abortions," Stevens explained. "The threat of failing to meet GME requirements will now be like a sword of Damocles hanging over their heads as well as over the heads of program administrators," Stevens noted.

"In everyday practice, when one resident attempts to opt out of the procedure, he or she can face intense pressure from colleagues who would be forced to take up the slack by performing more abortions," Stevens asserted. "The mandate will also effectively discourage those opposed to abortion on demand from entering the OB/GYN field."

CMDS chief operating officer Dr. Gene Rudd, an OB/GYN physician, explained that abortion training is unnecessary. "The skills required to perform first trimester abortions are acquired through learning dilation and curettage (D&C) and other procedures involving spontaneous abortions," Rudd noted. "Only the more controversial second and third trimester abortions require additional training.

"Does the Council's new policy mean," Rudd posited, "that all OB/GYN's who have not been trained to do abortions are inadequately prepared for professional practice? Of course not! There is absolutely no practical reason to force residents to learn to perform abortions if those residents do not intend to perform abortions in practice. Abortion training need not be considered an integral part of OB/GYN training, as evidenced by the fact that roughly a third of all residency programs in the U.S. do not even offer it."

To receive a free booklet on bioethical issues or for more information on the Christian Medical & Dental Society, contact CMDS at P.O. Box 830689, Richardson, TX 75083 or phone (214) 479-9173.

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO, Plaintiff, vs. ALEX M. AZAR II, et al., Defendants.	No. C 19-02405 WHA *Related to* No. C 19-02769 WHA No. C 19-02916 WHA
STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA, Plaintiff, vs. ALEX M. AZAR, et al., Defendants.	**SUPPLEMENTAL DECLARATION OF DR. RANDI C. ETTNER, PH.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT**
COUNTY OF SANTA CLARA, et al. Plaintiffs, vs. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	

I, Dr. Randi C. Ettner, declare as follows:

1. As detailed in my September 8, 2019 declaration submitted in support of the plaintiffs' motion for summary judgment, I am a licensed clinical and forensic psychologist with a specialization in the diagnosis, treatment, and management of gender dysphoric individuals. I also am the secretary and a member of the Board of Directors of the World Professional Association of Transgender Health (WPATH), and an author of the WPATH *Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People* (7th version).

2. I have been retained by counsel for Plaintiffs Trust Women Seattle, Los Angeles LGBT Center, Whitman-Walker Clinic, Inc. d/b/a Whitman-Walker Health, Bradbury-Sullivan LGBT Community Center, Center On Halsted, Hartford Gyn Center, Mazzoni Center, Medical Students For Choice, AGLP: The Association Of LGBTQ+ Psychiatrists, American Association of Physicians for Human Rights d/b/a Glma: Health Professionals Advancing LGBTQ Equality, Colleen Mcnicholas, Robert Bolan, Ward Carpenter, Sarah Henn, and Randy Pumphrey as an expert in connection with the above-captioned matter.

3. I submit this supplemental declaration in response to the Court's September 24, 2019 Notice Regarding Briefing requesting that the parties address "whether the word 'sterilization' as used in the Church Amendments was intended to cover transgender medical operations and/or gender reassignment surgery."

4. Attached as Exhibit A is a bibliography of additional relevant medical and scientific materials I have relied upon in forming the opinions herein, in addition to my years of experience and those already listed in my September 8, 2019 declaration.

5. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

I. EXPERT OPINIONS

6. A sterilization procedure is a medical procedure performed as a form of permanent birth control. Thus, a sterilization procedure is one that is *intended* to function as a form of permanent contraception.

7. The American College of Obstetricians and Gynecologists defines sterilization as "a permanent method of birth control." The U.S. Department of Health and Human Services similarly defines sterilization as "a form of contraception (birth control) that is meant to be permanent."

8. By contrast, gender-affirming health care, such as hormone replacement therapy or gender confirmation surgery (also known as gender reassignment surgery), are not sterilization procedures because they are not performed for the purpose of contraception. Gender-affirming health care is medically necessary for the treatment of gender dysphoria and can be life-saving for transgender individuals diagnosed with gender dysphoria.

9. To be sure, studies document how transgender individuals desire to have children and form families just like any other person (De Roo, et al., 2016; Wierckx, et al., 2012; De Sutter, et al., 2002). Indeed, a majority of transgender men desire to have children (Wierckx, et al., 2012).

10. Some transgender people can, and sometimes do, seek to preserve their ability to have children before undergoing any gender affirming medical procedure that will have an *incidental* effect on their fertility. Others, who have commenced cross-sex hormone therapy and choose to conceive, can stop hormonal treatment and stimulate reproductive organs.

11. There is documented evidence of transgender men becoming pregnant *after* transitioning and having undergone cross-sex hormone therapy (Light, et al., 2014; Wierckx, et al., 2012). Thus, transgender men are achieving pregnancy after having transitioned socially, medically, or both.

12. Among the options available for fertility preservation to transgender men are: (1) embryo banking; (2) oocyte banking; and (3) ovarian tissue cryopreservation (De Roo, et al., 2016; Finlayson, et al., 2016). Transgender women can also preserve their fertility through cryopreservation of sperm (De Roo, et al., 2016).

13. The options for fertility preservation available to transgender patients are no different from those available to cancer patients undergoing treatments, including chemotherapy and radiation, which can lead to infertility, a field known as oncofertility (Finlayson, et al., 2016).

14. It makes sense that the options for fertility preservation available to transgender patients are the same as those available to cancer patients. In both instances, the patient is obtaining medical treatment that may have an *incidental* effect on fertility, but which is obtained for the primary purpose of treating a medical condition and not for contraception. For example, a hysterectomy may be medically necessary for the treatment and alleviation of a transgender man's gender dysphoria, just as hysterectomy may be medically necessary for the treatment of uterine cancer or endometriosis.

15. Lastly, longitudinal studies show that gender confirmation surgery has been linked with a reduction in the need for mental health treatment for transgender patients (Branstrom, et al., 2019).

16. In other words, gender affirming health care is not a sterilization procedure. It is not performed for the purposes of contraception. Rather, gender affirming health care, including hormone replacement therapy and gender confirmation surgery, is medically necessary for the treatment and alleviation of a transgender patient's gender dysphoria, which is a serious medical condition that can result in significant clinical distress, debilitating depression, and suicidality.

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I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated this 7 day of October, 2019.

Respectfully submitted,

Dr. Randi C. Ettner

Dr. Randi C. Ettner

EXHIBIT A

BIBLIOGRAPHY

Am. Coll. of Obstetricians and Gynecologists. FAQ011 – Contraception – Sterilization for Men and Women (Mar. 2019), available at: https://www.acog.org/-/media/For-Patients/faq011.pdf?dmc=1&ts=20191005T1757186748.

Bränström R., Pachankis J.E. *Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study*. Am. J. Psychiatry. (2019)

De Roo C., Tilleman K., Tsjoen G., De Sutter P. *Fertility options in transgender people.* International Review of Psychiatry. (2016) 28(1):112–119.

De Sutter P., Kira K., Verschoor A., Hotimsky A. *The desire to have children and the preservation of fertility in transsexual women: A survey.* International Journal of Transgenderism. (2002) 6(3).

Finlayson C., Johnson E. K., Chen D., et al. *Proceedings of the Working Group Session on Fertility Preservation for Individuals with Gender and Sex Diversity.* Transgender Health. (2016) 1(1):99–107.

Light A. D., Obedin-Maliver J., Sevelius J. M., Kerns J. L. *Transgender men who experienced pregnancy after female-to-male gender transitioning.* Obstetrics & Gynecology. (2014) 124(6):1120–1127.

Office of Population Affairs, U.S. Dept. of Health and Human Servs., *Sterilization*, *available at*: https://www.hhs.gov/opa/pregnancy-prevention/sterilization/index.html (last accessed Oct. 5, 2019).

Wallace S. A., Blough K. L., Kondapalli L. A. *Fertility preservation in the transgender patient: Expanding oncofertility care beyond cancer.* Gynecological Endocrinology. (2014) 30(12):868–871.

Wierckx K., Van Caenegem E., Pennings G., et al. *Reproductive wish in transsexual men.* Human Reproduction. (2012) 27(2):483–487.