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Submitted Electronically

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Conscience NPRM
RIN 0945-AA18
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

Subj: Safeguarding the Rights of Conscience as Protected by Federal Statutes, RIN 0945-AA18

Dear Sir or Madam:

On behalf of the United States Conference of Catholic Bishops ("USCCB"), we submit the following comments on the proposed rule to protect conscience rights in health care. 88 Fed. Reg. 820 (Jan. 5, 2023).

I. Background

Pope Francis has repeatedly affirmed the fundamental importance of the right of conscience. Addressing a professional association of pharmacists in 2021, he observed that "You are always at the service of human life. In some cases this can lead to conscientious objection, which is not disloyalty, but on the contrary fidelity to your profession, if validly motivated... [T]his is the ethical intimacy of every health professional and this should never be negotiated, it is the ultimate responsibility of health professionals. It is also a denunciation of the injustices done to the detriment of innocent and defenceless life."[1] In 2017, he stated that "Religious freedom, including freedom of conscience, rooted in the dignity of the person, is the cornerstone of all other freedoms. It is a sacred and inalienable right."[2] The previous year, he condemned

[1] Address of His Holiness Pope Francis to the Participants on the Congress Promoted by the Italian Society of Hospital Pharmacy and Pharmaceutical Services of Health Authorities, October 14, 2021, available at https://www.vatican.va/content/francesco/en/speeches/2021/october/documents/20211014-farmaceutica-ospedaliera.html.
[2] Address of His Holiness Pope Francis, April 28, 2017, available at https://www.vatican.va/content/francesco/en/speeches/2017/april/documents/papa-francesco_20170428_egitto-tawadros-ii.html#Common_Declaration.

"the sort of persecution that is polite, disguised as culture, modernity and progress, and which ends up taking away man's freedom and even the right to conscientious objection."[3]

This emphasis on the primacy of the right of conscience exists in harmony with the Church's longstanding ministry to the sick and support for health care for all people.

Catholics have been called to care for the sick since the earliest days of our faith. Here in America, the Ursuline nuns ran the Royal Hospital in New Orleans before our country declared its independence from Britain.[4] Today, with hundreds of hospitals and health care facilities affiliated with the Catholic Church in operation, Catholic entities taken together are the largest nonprofit health care provider in this country.[5] We do this work in fulfillment of the direct command of Jesus Christ (Mt. 10:8-10)[6] and in imitation of his divine ministry here on Earth.

We serve all in need, without regard to race, religion, sex, or any other characteristic, because we believe that health care is a basic human right. As the USCCB's predecessor organization, the National Conference of Catholic Bishops, stated in 1993, "This right flows from the sanctity of human life and the dignity that belongs to all human persons, who are made in the image of God."[7] The same core beliefs about human dignity and the wisdom of God's design that motivate Catholics to care for the sick also shape our convictions about preborn children, sexual conduct, and the immutable nature of the human person. These commitments are inseparable.

These foundational beliefs also positively affect the quality of the care we provide. Nonprofit religiously affiliated hospitals "save more lives, release patients from the hospital sooner, and have better overall patient satisfaction ratings."[8] Religious hospitals "demonstrated significantly better results than for-profit and government hospitals on inpatient and 30-day mortality, patient safety, length of stay, and patient satisfaction."[9] Catholic hospitals care for more than one of seven hospital patients in the United States.[10]

Because health care ineluctably raises questions of religious significance – of life and death, and what it means to be healthy and flourish – the protection of conscience and religious freedom in health care is particularly important. This is true not only of health care providers, as described above, but of health care consumers as well. A health care industry devoid of any

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[3] Two Kinds of Persecution, April 12, 2016, available at https://www.vatican.va/content/francesco/en/cotidie/2016/documents/papa-francesco-cotidie_20160412_two-kinds-of-persecution.html.
[4] John E. Salvaggio, *New Orleans' Charity Hospital: A Story of Physicians, Politics, and Poverty* 8 (1992).
[5] Catholic Health Ass'n, Catholic Health Care in the United States, at 1 (Mar. 2021), www.chausa.org/about/about/facts-statistics.
[6] "Cure the sick, raise the dead, cleanse lepers, drive out demons. Without cost you have received; without cost you are to give. Do not take gold or silver or copper for your belts; no sack for the journey, or a second tunic, or sandals, or walking stick. The laborer deserves his keep."
[7] https://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/health-care-comprehensive-care.pdf.
[8] David Foster et al., Hospital Performance Differences by Ownership 1 (June 2013), http://docplayer.net/13886677-Hospital-performance-differences-by-ownership.html.
[9] *Id.* at 2.
[10] Catholic Health Ass'n, *supra*, note 5.

sensitivity to, or understanding of, the religious beliefs of its patients would not well serve our religiously diverse citizenry.

II. Preamble

The proposed rule's preamble addresses the court rulings that vacated the 2019 Rule,[11] and how those rulings shape the proposed rule text. Some of the preamble's discussion of the bases on which courts vacated the 2019 Rule bears not only on the proposed rule's omission of definitions of statutory terms and other substantive aspects of the 2019 Rule, but also on how the Department would apply the federal health care conscience statutes on a case-by-case basis under the proposed rule.

The preamble argues that the federal health care conscience statutes should be interpreted to reflect the "balance Congress struck between safeguarding conscience rights and protecting access to health care."[12] In particular, the preamble argues that, while on the one hand health care providers have rights protected by the federal health care conscience statutes,

> Patients also have autonomy, rights, and moral and religious convictions. And they have health needs, sometime urgent ones. Our health care systems must effectively deliver services—including safe legal abortions—to all who need them in order to protect patients' health and dignity.[13]

While this reasoning echoes that of the courts that vacated the 2019 Rule, especially with regard to the requirements of Title VII of the Civil Rights Act of 1964 and the Emergency Medical Treatment and Labor Act (EMTALA), the preamble does not say whether the Department adopts the courts' rulings in those regards. It only mentions Title VII and EMTALA in the context of summaries of comments received on the 2019 Rule. So it is unclear what legal basis the Department has in mind for its assertions that the federal health care conscience statutes must be balanced against anything else.

In any event, there is no cognizable legal rationale or policy interest for the killing of preborn children. It cannot be found in the Constitution.[14] Nor does EMTALA require abortions, but rather the stabilization of the patients – both "the individual and, in the case of labor…the unborn child."[15] The perceived conflict between EMTALA and conscience protections about abortion seems in part based on widespread misconceptions about what most religiously motivated health care providers regard as a direct abortion – misconceptions that have also

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[11] *Washington v. Azar*, 426 F. Supp. 3d 704 (E.D. Wash. 2019), appeal pending, No. 20–35044 (9th Cir.); *City & Cnty. of San Francisco v. Azar*, 411 F. Supp. 3d 1001 (N.D. Cal. 2019), appeal pending, Nos. 20–15398 et al. (9th Cir.); *New York v. HHS*, 414 F. Supp. 3d 475 (S.D.N.Y. 2019), appeal pending, Nos. 19–4254 et al. (2d Cir.).
[12] 88 Fed. Reg. at 825.
[13] 88 Fed. Reg. at 826.
[14] *Dobbs v. Jackson Women's Health Organization,* 142 S. Ct. 2228 (2022).
[15] 42 U.S.C. 1395dd(c)(1)(A)(ii).

generated confusion in the context of state restrictions on abortion since the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*.[16]

During President Obama's administration, the Department recognized that there is no conflict between the federal health care conscience statutes and EMTALA, stating that:

> The conscience laws and the other federal statutes have operated side by side often for many decades. As repeals by implication are disfavored and laws are meant to be read in harmony, the Department fully intends to continue to enforce all the laws it has been charged with administering…. [E]ntities must continue to comply with their… EMTALA… obligations, as well as the federal health care provider conscience protection statutes.[17]

Certainly it is true that "patients have autonomy, rights, and religious beliefs and moral convictions." As described above, the USCCB is committed to advancing affordable and high-quality health care for all Americans, which entails that due concern be paid to these and other interests of patients as individuals. But it is unclear how the Department envisions patients' autonomy, rights, and religious beliefs and moral convictions – which in this context would seem to be best understood as a reference to negative rights, protecting patients *from* discrimination or *from* being forced to do anything against their will – as placing any limitations on health care providers' rights of conscience. *The federal health care conscience statutes protect objections to procedures, not objections to patients*. And patients' rights to personal autonomy or to exercise one's religious beliefs or moral convictions cannot be weaponized into forcing health care providers to violate their own legally protected conscientious objections.

Confusingly, alongside its assertion that the federal health care conscience statutes exist in some state of balance with other statutes or policy objectives, the Department implies that its approach to enforcement of the statutes under the proposed rule would be to use "the general framework that OCR has been employing since 2011—applying the plain text of the underlying statutes to the facts at issue on a case-by-case basis."[18] This is hard to square with the suggestion that those statutes must be balanced against external interests or constraints. The plain text of the most significant federal health care conscience statutes – the Church, Coats-Snowe, and Weldon Amendments – sets out *absolute* protections for the right of conscience.[19]

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[16] *See, e.g.*, "AAPLOG Statement: Clarification on Abortion Restrictions" ("AAPLOG does not support the conflation of elective abortion with other appropriate medical interventions and treatments performed to save the life of the mother"), https://aaplog.org/aaplog-statement-clarification-of-abortion-restrictions/.

[17] Department of Health and Human Services, "Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws," 76 Fed. Reg. 9968, 9973-74 (Feb. 23, 2011) (emphasis added).

[18] 88 Fed. Reg. at 824.

[19] 42 U.S.C. § 300a-7(d) (Church Amendment) ("*No individual shall be required* to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services *if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions*") (emphasis added); 42 U.S.C. § 238n(a)(1) (Coats-Snowe Amendment) ("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…the entity refuses* to undergo training in the performance of induced abortions…") (emphasis added);

Besides attempting to manufacture a conflict with EMTALA that has never yet materialized, the courts that vacated the 2019 Rule held that its broad construction of the federal health care conscience statutes unlawfully displaced Title VII's application to employees' religious exercise in the health care workplace environment.[20] The text of Title VII permits an employer to avoid liability for religious discrimination if the employer "demonstrates that he is unable to reasonably accommodate to an employee's or prospective employee's religious observance or practice without undue hardship on the conduct of the employer's business." The conscience statutes contain no such qualifications. Yet the courts found the 2019 Rule to be contrary to law for not importing Title VII's accommodation framework into the conscience statutes, reasoning that "HHS has not pointed to any evidence of congressional intent to supersede the Title VII framework."[21]

It is ironic that the courts' reasoning on this issue fails under the approach to statutory interpretation used in the Supreme Court's decision in *Bostock v. Clayton County, Georgia*, itself a case about how to interpret the meaning of Title VII: "[W]hen the meaning of the statute's terms is plain, our job is at an end. The people are entitled to rely on the law as written, without fearing that courts might disregard its plain terms based on some extratextual consideration."[22] The courts that vacated the 2019 Rule construed the relationship between the federal health care conscience statutes and Title VII in a way that robs the conscience statutes of their plain meaning – the meaning that *Bostock* indicates the Department must ascribe to them.

III. Regulatory Impact Analysis (RIA)

The proposed rule requests comment on whether the non-quantified impacts identified in the 2019 Final Rule's RIA would likely be realized, absent any further regulatory action; and requests comment on the extent to which each of the identified policy options, including the proposed rule, would result in comparable impacts.

We endorse the 2019 Rule's analysis of non-quantified impacts expected to result from that rulemaking. Given that the 2019 Rule was vacated, its anticipated impacts would not be realized if the Department takes no further regulatory action. Because the proposed rule offers only hints in its preamble about how the Department will interpret the subject statutes in the course of enforcement, it is difficult to estimate the degree to which the proposed rule, or a version of the proposed rule in which the notice is mandatory, will result in the same impacts. For instance, if the Department interprets the statutory protections to be effectively capped by

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Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, Div. H, § 507(d)(1) (Weldon Amendment) ("None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that *the health care entity does not* provide, pay for, provide coverage of, or refer for abortions") (emphasis added).

[20] 42 U.S.C. 2000e(j).

[21] *New York* at 536.

[22] *Bostock v. Clayton County, Georgia*, 140 S.Ct. 1731, 1749 (2020). *See also* Tara Leigh Grove, "Which Textualism?", 134 Harv. L. Rev. 265, 267 (2020) ("The majority opinion [in *Bostock*] applied ... an approach that instructs interpreters to carefully parse the statutory language, focusing on semantic context and downplaying policy concerns or the practical (even monumental) consequences of the case").

Title VII's current standard, the benefits of the final rule will be less than if the Department applied the plain meaning of the statutes. The Supreme Court's recent decision to grant certiorari in *Groff*, a case inviting the Court to reconsider *TWA v. Hardison*, 432 U.S. 63 (1977), underscores the question.[23]

One substantial difference in impact among the policy options would be in the awareness the rule would generate of the existence of the federal health care conscience statutes and the protections they provide. Making the notice mandatory would do the most toward this objective. Note, however, our comments regarding the proposed model text for the notice, in the discussion below.

IV. Rule text

In general, the proposed rule's text appears to be designed to avoid providing a basis for legal claims like those lodged against the 2019 Rule. While certainly it is prudent to consider the reasoning of the courts that vacated the 2019 Rule, the proposed rule defers too much to their reasoning and in some cases needlessly goes beyond what they require. Instead, the rule should go further in order to protect conscience rights by restoring more of what was omitted from the 2019 Rule.

a. 88.1 - Purpose (proposed amendments)

We support the proposed rule's retention of the full range of federal health care conscience statutes that were included in the 2019 Rule. The inclusion of these statutes has the obvious practical significance of breathing life into them by facilitating their enforcement, but also the symbolic significance of affirming that Congress has time and again sought to protect conscience rights in health care.

b. 88.2 - Complaint handling and investigating (proposed amendments to 2019 Rule Section 88.7, renumbered)

We support the proposed rule's retention of a basic framework for OCR to handle and investigate complaints of violations of the federal health care conscience statutes.

Because the internal process for handling and resolving complaints is not subject to one of the primary bases on which the 2019 Rule was vacated – the finding that the Department lacked statutory authority to engage in substantive rulemaking – the Department can and should establish a more robust enforcement framework than the proposed rule text provides.

i. Failure to respond

The proposed rule deletes the 2019 Rule's provision establishing that the failure of an entity to respond to an OCR investigation can constitute a violation of the regulation. Without such a provision, OCR will be unable to conduct effective investigations, as entities under investigation will be able to withhold crucial information with impunity. If the Department has determined that imposing an obligation to respond would constitute impermissible substantive

[23] *Groff v. DeJoy*, No. 22-174 (Jan. 13, 2023) (granting certiorari).

rulemaking – a determination we believe would be incorrect and would have no basis in the court rulings that vacated the 2019 Rule – then the final rule should at least permit OCR to adopt a negative inference with regard to any factual question to which the investigated entity fails to respond.

ii. Formal means

Paragraph 88.2(d)(2) of the proposed rule states that OCR will resolve investigations "by informal means whenever possible" but does not provide for the use of formal means. The 2019 Rule specified that any formal means undertaken to achieve compliance would be carried out through the enforcement frameworks of existing regulations governing Federal financial assistance from HHS, such as the Uniform Administrative Requirements. The courts that vacated the 2019 Rule did not find that the use of such avenues of formal means were impermissible per se, but only that the 2019 Rule text deviated from those existing frameworks in specific ways.[24] Rather than foreswear enforcement via formal means, the final rule should retain OCR's explicit authority to pursue formal enforcement while amending the 2019 Rule's provisions in a targeted way to ensure consistency with the avenues of enforcement available under existing regulations.

iii. Withdrawal or termination of funding

The proposed rule omits any mention of what consequences may come with enforcement of the rule via formal means, such as withdrawal or termination of the Federal financial assistance that is the nexus for the pertinent statute's application to the entity. Here, too, the reasoning supporting the vacaturs of the 2019 Rule does not require wholesale recission of these rule provisions, but rather clarifying amendments that preclude only enforcement in a manner that would violate the Spending Clause or the principle of separation of powers.

c. 88.3 - Notice (proposed amendments to 2019 Rule Section 88.5, renumbered)

We support the Department's decision to specify that, while it encourages providers to list on its notice any alternative providers for procedures to which the provider has a conscience-based objection, such information is not required in the notice. This is prudent observance of the Supreme Court's decision in *NIFLA v. Becerra*.[25]

d. Appendix A – amendments to model text of notice

The model text will make it hard for covered entities to draft accurate notices and – critically – will often fail to meaningfully inform protected individuals of their rights.

The text provides a placeholder that covered entities can fill in with a list of the conscience statutes that apply to them. However, the rule text itself, by deleting Section 88.3 of the 2019 Rule, offers no information to covered entities about what statutes apply to them. Each federal health care conscience statute imposes different compliance obligations and applies to a

[24] *See New York* at 515 ("The 2019 Rule goes beyond the UAR in two respects.").
[25] *Nat'l Inst. of Fam. & Life Advocs. v. Becerra*, 201 L. Ed. 2d 835, 138 S. Ct. 2361 (2018) (striking down a state requirement that pro-life pregnancy centers post a notice providing women with contact information for how to obtain abortions).

different stream of funds. Therefore, unlike with notices for Title VI, Title IX, or Section 504, covered entities cannot know what their obligations are simply by virtue of their receipt of any Federal financial assistance from the Department. This was a problem that Section 88.3 of the 2019 Rule sought to address by providing an exhaustive and detailed description of who is covered by each statute implemented by the rule. The Department's proposal provides only an incomplete summary of who is covered by which statute, and only does so in the preamble, which will be more difficult than the rule text for covered entities to find when researching what their obligations are.

The text also provides no description at all of what the federal health care conscience statutes require. While it is true that a broad description of those statutes' requirements may not be accurate as applied to a particular covered entity, total omission of any such information will make the notice nearly useless to any protected individual reading it. Instead, the notice should include a description of the general nature of the conscience statutes, with an acknowledgment that they "may" apply to a covered entity (which avoids the problem of an inaccurate guarantee of applicability), such as that provided in the 2019 Rule's model text.[26] Alternatively, the Department could provide suggested summary blurbs for each statute, which covered entities can use to describe the requirements of the statutes they are subject to.

e. Deletion of relationship to other laws (2019 Rule Section 88.8)

Even if the Department lacks authority to issue substantive regulations interpreting any or all of the federal health care conscience statutes, it cannot pretend that it will not engage in some interpretation of the meaning of those statutes in the course of its enforcement efforts. The proposed rule should set out, for internal administrative purposes, and in at least general terms, principles governing how the Department will interpret the federal health care conscience statutes in relation to other laws. In the absence of definitions clarifying the meaning of the statutes, such a provision would provide some measure of guidance to covered entities about how the Department understands the statutes subject to the proposed rule.

f. Deletion of rule of construction (2019 Rule Section 88.9)

Courts and administrative agencies have long recognized that non-discrimination laws should be construed broadly to give full effect to their remedial purposes.[27] It would be entirely appropriate, therefore, for HHS to announce a rule of broad construction here. This would offer some degree of insight to covered entities about how the Department will enforce the federal health care conscience statutes.

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[26] "You may have the right under Federal law to decline to perform, assist in the performance of, refer for, undergo, or pay for certain health care-related treatments, research, or services (such as abortion or assisted suicide, among others) that violate your conscience, religious beliefs, or moral convictions." 84 Fed. Reg. at 23272.

[27] *Tcherepnin v. Knight*, 389 U.S. 332, 336 (1967) (it is a "familiar canon of statutory construction that remedial legislation should be construed broadly to effectuate its purposes"); *see, e.g., Disabled in Action v. Southeastern Pa. Transp. Auth.*, 539 F.3d 199, 208 (3d Cir. 2008) (the Americans with Disabilities Act "'is a remedial statute, designed to eliminate discrimination against the disabled in all facets of society,' and as such, 'it must be broadly construed to effectuate its purposes'").

g. Statutes for which the Department has clear rulemaking authority

The Department has explicit statutory authority to engage in substantive rulemaking on the conscience protections set out in Sections 1303, 1411, and 1553 of the Affordable Care Act, 42 U.S.C. 18023, 18081, and 18113; and certain Medicare and Medicaid provisions, 42 U.S.C. 1320a–1(h), 1320c–11, 1395i–5, 1395w–22(j)(3)(A)–(B), 1395x(e), 1395x(y)(1), 1395cc(f), 1396a(a), 1396a(w)(3), 1396u–2(b)(3)(A)–(B), 1397j–1(b), and 14406.[28] The Department should exercise that authority in full.

This should include requiring assurances and certifications of compliance with these statutes by covered entities, as in Section 88.4 of the 2019 Rule, and establishing compliance requirements comparable to those applicable to other civil rights laws, as in Section 88.6 of the 2019 Rule. The final rule should also include definitions of terms in those statutes for clarity and broad protection of conscience rights, as in Section 88.2 of the 2019 Rule. These definitions should be informed by a proper understanding of the relationship between the statutes and Title VII and EMTALA, as discussed above in Section II of these comments.

In the preamble to the proposed rule, the Department requested comment on whether the 2019 Rule provided sufficient clarity to minimize the potential for harm resulting from any ambiguity and confusion that may exist because of the rule, and whether any statutory terms require additional clarification (beyond, we presume, the clarity provided by the statutes themselves). At least in relation to the proposed rule's approach of not defining any terms even in the case of statutes under which it has explicit rulemaking authority, the answer to both questions is surely yes.

V. Conclusion

We support the proposed rule as an improvement over the current status quo in which the 2019 Rule is vacated. Yet we also urge the Department to strengthen the proposed rule in ways available to it, as discussed above. Thank you for your consideration of our comments.

[28] *New York* at 529; *City and Cnty. of San Francisco* at 1023.