American Association of Pro-Life Obstetricians and Gynecologists
Comments on Notice of Proposed Rulemaking for1557 0945-AA17 Nondiscrimination in Health Programs and Activities,
Submitted October 3, 2022

AAPLOG exists to provide the evidence-based effects of abortion on women as well as the scientific fact that human life begins at the moment of fertilization, with the goal that all women, regardless of race, creed or national origin, will be empowered to make healthy and life-affirming choices. On behalf of thousands of AAPLOG members, we respectfully submit these comments in opposition to the proposed rule.

The American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG) is aware of and concurs with the significant medical issues and conscience concerns for health care professionals raised by the Coalition for Jewish Values and the Coalition for Jewish Values Health Care Council, as well as the comments from the Catholic Health Care Leadership Alliance and the Christian Medical and Dental Association. As a non-sectarian organization, AAPLOG can attest that the concerns raised by these faith based groups are also concerns which affect non-sectarian health professionals as well. In addition, AAPLOG provides the following summary and details of our concerns as non-sectarian reproductive health medical professionals.

Summary of Comments

The Notice of Proposed Rulemaking (NPRM) 1557 0945-AA17 as published in the Federal Register August 4, 2022 is contradictory and vague, and represents a flagrant violation not only of established law but also of medical common sense. The proposed rule violates the conscience rights of medical professionals and attempts to insert federal agencies into sensitive physician-patient relationships. This usurpation by the Department attempts to override the professional medical judgement of a physician in the physician-patient relationship. The proposed rule nonsensically inserts abortion into the definition of sex discrimination. The abortion neutrality provision from Title IX is not imported into 1557, but this NPRM incorporates Title IX. So, despite the fact that abortion neutrality is the clear wording of statutes that the NPRM proports to rely upon, the proposed rule picks and chooses what parts of the settled law it wants to consider and what parts it clearly and blatantly ignores, thus rendering this proposed rule a law unto itself and making it inconsistent with the very rules it cites. This proposed rule must be voided.

Details:

Source for these comments are from Federal Register /Vol .87, No 149/ Thursday August 4 2022 Proposed Rules pages 47824-47913, also attached in the appendices to this submission. The quotations from the NPRM are in highlighted italics. The page numbers cited refer to the pages in the NPRM.

"*The 2016 Rule was challenged under the Administrative Procedure Act[18] (APA) and the Religious Freedom Restoration Act[19] (RFRA). Before the rule went into effect, the United States (U.S.) District Court for the Northern District of Texas, in Franciscan Alliance v. Burwell, enjoined the Department from enforcing the 2016 Rule's prohibition against discrimination on the basis of gender identity or termination of pregnancy.[20] Subsequently, on October 15, 2019, the same district court vacated the 2016 Rule insofar as the 2016 Rule defined discrimination on the basis of sex to include gender identity and termination of pregnancy.[21] In 2021, the court in Franciscan Alliance issued an order enjoining the Department from interpreting or enforcing Section 1557 against the plaintiffs in that case in a manner that would require them to perform or provide insurance coverage for gender transition services or abortion* [1]

The NPRM clearly outlines the fact that federal courts have ruled it impermissible lump provision of abortion services into the category of sex discrimination. Yet this NPRM goes on to disregard the very clear federal legal guidance by lumping abortion into the category of sex discrimination. The Department in this NPRM ignoring the parts of the law which the Department finds inconvenient or does not fit into the Department's view, thus putting the Department's political opinion above the law itself. The NPRM's proposed changes are an untenable violation of the purpose of the Centers for Medicare & Medicaid Services (CMS) and Health and Human Services (HHS). Neither CMS nor HHS are above the law.

"*Following the issuance of the 2020 Rule, which included an effective date of August 18, 2020,[33] litigants in various U.S. District Courts sought to enjoin the rule on the basis that it was, among other allegations, arbitrary and capricious and contrary to law under the APA.[34] While these challenges addressed a range of changes made to the 2016 Rule, they primarily focused on the 2020 Rule's repeal of the definition of ''on the basis of sex''; the incorporation of provisions governing the 2020 Rule's relationship to other laws related to various religious exemptions; the scope of coverage; and the elimination of language access provisions. As a result of these challenges, the Department is currently preliminarily enjoined from enforcing its repeal of certain portions of the 2016 Rule's definition of ''on the basis of sex,'' and of former 45 CFR 92.206, regarding equal program access on the basis of sex, as well as from enforcing the 2020 Rule's incorporation of Title IX's religious exemption.[35] The five pending lawsuits were stayed for the Department's review of the 2020 Rule.*

3. May 10, 2021 Notification of Interpretation (''Bostock Notification'') On May 10, 2021, the Department publicly announced, consistent with the Supreme Court's decision in Bostock, that the

[1] 87 Fed. Reg. 47826

Department would interpret Section 1557's prohibition on sex discrimination to include (1) discrimination on the basis of sexual orientation and (2) discrimination on the basis of gender identity (''Bostock Notification'').[36] The Department explained that its interpretation will guide OCR's complaint processing and investigations; however, the interpretation did not ''determine the outcome in any particular case or set of facts.'' In addition, the Department explained that its Section 1557 enforcement will comply with RFRA and all other legal requirements, including applicable court orders that have been issued in litigation involving Section 1557 regulations.

There are currently three court challenges to the Department's Bostock Notification, generally alleging violations of the APA and RFRA.[37] As of this writing, two opinions have been issued: (1) the district court in Neese v. Becerra denied the defendants' motion to dismiss, finding that the plaintiffs plausibly pled that neither Section 1557 nor Bostock prohibit health care providers from discriminating on the basis of sexual orientation and gender identity,[38] and (2) the district court in Christian Employers Alliance v. EEOC has preliminarily enjoined the Department from interpreting or enforcing Section 1557 and its implementing regulations against plaintiffs in a manner that would require them to provide, offer, perform, facilitate, or refer for gender transition services or that prevents, restricts or compels the plaintiffs' speech on gender identity issues.[39] All three cases remain pending.''[2]

Despite acknowledging in the above section that the overbroad and overreaching interpretations by HHS are under legal challenge, and despite no court ever upholding HHS in it's determination that sex discrimination includes the provision of abortion, the HHS through this NPRM makes the unsubstantiated assertion that somehow discrimination on the basis of sex involves provision of abortion. Not only is such a claim medically incoherent, but it is also refuted in the previous rules that this NPRM cites as will be expanded upon later in this document.

"*This proposed rule would reflect Section 1557's application to health programs and activities of the Department, which holds the Department accountable to the same standards of compliance with civil rights laws to which it holds recipients of Federal financial assistance. The proposed rule would also reinstate the rule clarifying that Section 1557 generally applies to many health insurance issuers and also prohibits discrimination in health insurance and other health-related coverage,[3] furthering a central goal of the ACA— to increase access to health-related coverage—by ensuring that Section 1557's robust civil rights protections apply to health insurance and other health-related coverage.*"[4]

Incongruously, the NPRM intends to override and ignore previous legislation concerning the application of "sex discrimination" to abortion services and impose this view on all recipients of federal funding, in a raw exercise of power flouting existing laws and pending rulings.

---

[2] 87 Fed. Reg. 47827.

[3] The term ''health coverage'' generally refers to a ''[l]egal entitlement to payment or reimbursement for your health care costs, generally under a contract with a health insurance company, a group health plan offered in connection with employment, or a government program like Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).'' *Glossary: Health coverage, HealthCare.gov, https:// www.healthcare.gov/glossary/health-coverage/* (last visited June 15, 2022).

[4] 87 Fed. Reg. 47827.

"Further, the rule proposes to ensure equal program access on the basis of sex and prohibit discrimination on the basis of sex related to marital, family, or parental status. The Department additionally proposes provisions related to nondiscrimination in the use of clinical algorithms in health care decision-making and in telehealth services."[5]

AAPLOG requests the Department to clarify what is meant by the term "equal program access".

AAPLOG also requests the Department to clarify what is meant by "nondiscrimination in the use of clinical algorithms in health care decision-making and in telehealth services"

The proposed rule arrogates to itself the final say in medical algorithms, for which lawmakers have no expertise, in order to bludgeon the medical profession into compliance with the Administration's political views. This is an unprecedented power grab on the part of HHS, and a power grab for which they have neither the legal authority nor the scientific or medical expertise.

"*Upon further consideration and informed by civil rights issues raised in the context of the coronavirus disease 2019 (COVID–19) pandemic, the Department believes that the 2020 Rule creates substantial obstacles to the Department's ability to address discrimination across the health programs and activities it financially supports or administers, thereby undermining the statutory purpose of Section 1557 and hindering the Department's mission of pursuing health equity and protecting public health*."[6]

In the guise of "pursuing health equity" and public health, the Department uses the threat of violating the non-discrimination law to force health entities and medical professionals into performing or referring for elective abortions. But this reasoning is simply a disguise for forcing health care entities and medical professionals to take part in the killing of the human beings in the womb-who are patients for whom medical professionals have a Hippocratic responsibility to care for and protect.

AAPLOG asks for clarification from the Department for the following questions:

1. **What public health interest does the Department have in promoting the elective killing of preborn human beings?**
2. **What is the compelling government interest which prompts the Department's advocacy for promotion of elective abortion?** And especially,
3. **Where does the Department get the authority to force compliance with the promotion and performance of elective abortion when previous rules cited in this document clearly exclude abortion, and the coercion for performance of abortion from the definition of sex discrimination?**

[5] 87 Fed. Reg. 47828.
[6] 87 Fed. Reg. 47828.

"In its Bostock Notification, the Department affirmed its commitment to complying with RFRA and all other legal requirements supporting religious exercise and freedom of conscience while also affirming Section 1557's prohibition of discrimination on the basis of gender identity and sexual orientation."[7]

The NPRM clearly states that the Department affirms its commitment to complying with RFRA and all other legal requirements supporting religious exercise and freedom of conscience. Yet this statement is only lip service and is inconsistent with what the NPRM states later when it goes on, despite the precedent of other rules to the contrary, to equate "termination of pregnancy" as a protected category under sex discrimination. As such, the current NPRM is inconsistent, incoherent and self-contradictory in relation to the inclusion of "termination of pregnancy" under sex discrimination, making it arbitrary and capricious. Despite claiming to provide clarity, the NPRM itself creates unnecessary confusion in compliance and is inconsistent with the previous agency positions that it cites.

"D. Proposed Changes Are Consistent
With the Statute and Will Further the Intended Purpose of the Statute

Despite the best efforts of many health care professionals, inequities in access to health care resulting in disparities in health status and outcomes persist. Such disparities pose a major public health challenge for the United States and hinder efforts by health care professionals who work to ensure that their patients receive quality care. As discussed throughout this preamble, discrimination in health care can contribute to these disparities, which negatively impacts communities of color, individuals with disabilities, women, lesbian, gay, bisexual, transgender,[8] queer, and intersex[9] (LGBTQI+)[10] individuals, LEP individuals, and older adults and children. Critically, access to health care that is free from discrimination benefits all communities and people, and is also vital to addressing public health emergencies, such as the COVID–19 pandemic. For example, ensuring nondiscriminatory access to health care, vaccines, and protective equipment during a public health emergency will more effectively and expeditiously end the emergency for everyone.[11]

Strong civil rights protections play a significant role in advancing an equitable society, and every part of government must contribute to ensuring that people in the United States enjoy the protections guaranteed to them. Since taking office, President Biden has issued more than a dozen directives aimed

---

[7] 87 Fed. Reg. 47829.
[8] When used in this preamble, the term ''transgender'' refers to people who identify as a gender other than their sex assigned at birth. This may include people who identify as nonbinary, genderqueer, or gender nonconforming, regardless of whether those individuals explicitly use the term transgender to describe themselves.
[9] When used in this preamble, the term ''intersex'' refers to people born with variations in physical sex characteristics—including genitals, gonads, chromosomes, and hormonal factors—that do not fit typical binary definitions of male or female bodies.
[10] We use ''+'' in this acronym to indicate inclusion of individuals who may not identify with the listed terms but who have a different identity with regards to their sexual orientation, gender identity, or sex characteristics.
[11] *See, e.g.,* Ann Lee & Sheila David, *Ensuring Equitable Access to Vaccines,* Stan. Soc. Innovation Rev., Jun. 29, 2021, *https://ssir.org/articles/entry/ensuring_equitable_access_to_vaccines#.*

at promoting equity, including the robust enforcement of civil rights.[121314] Discrimination in health programs and activities can lead to disparate health outcomes and adverse differences in access to care.[80] Accordingly, the Department is committed to doing its part to eliminate such discrimination, including through robust implementation and enforcement of Section 1557. Moreover, the Department is committed to addressing different, intersecting forms of discrimination experienced by individuals who may be entitled to protection from discrimination on more than one of the protected bases under Section 1557 and whose experience of discrimination may be both quantitatively and qualitatively different from that of individuals experiencing single-basis discrimination."[15]

This verbiage highlights a litany of real difficulties which are multifactorial, and most are unrelated to sex discrimination. The NPRM does not at all explain how the inclusion of "termination of pregnancy" in the term "sex discrimination" has anything at all to do with the disparities mentioned above or how those disparities will be alleviated by prohibiting discrimination based on "termination of pregnancy."

"Health Equity and Discrimination Related to Race, Color, and National Origin
Members of racial and ethnic groups that have historically faced discrimination and structural disadvantages in the United States experience disproportionately poor health status.[16] Though health indicators for aggregated racial and ethnic populations may suggest positive outcomes for some groups, broad demographic categories often conceal health disparities within and among racial and ethnic subgroups. For example, positive overall data on the health of persons of Asian descent often obscure disparities among subgroups.[82] One study revealed that while Asian persons in the aggregate appeared to be healthier than white persons in the United States, disaggregation of the data shows that persons of Filipino descent experience a higher prevalence of fair or poor health, obesity, high blood pressure, diabetes, or asthma when compared with white persons.[83] Similarly, while the rate of low birth weight infants is lower for the total Hispanic/Latino population in the
United States in comparison to non- Hispanic white people, Puerto Ricans have a low birth weight rate that is almost twice that of non-Hispanic white people.[84]"[17]

---

[12] *See, e.g.*, E.O. 13985, 86 FR 7009 (2021); E.O.
[13] , 86 FR 7023 (2021); E.O. 13995, 86 FR 7193 (2021); Memorandum on Redressing Our Nation's and the Federal Government's History of Discriminatory Housing Practices and Policies (2021), *https://www.whitehouse.gov/briefing-room/ presidential-actions/2021/01/26/memorandum-on- redressing-our-nations-and-the-federal- governments-history-of-discriminatory-housing- practices-and-policies/;* Memorandum on Condemning and Combating Racism, Xenophobia, and Intolerance Against Asian Americans and Pacific Islanders in the United States (2021), *https://www.whitehouse.gov/briefing-room/ presidential-actions/2021/01/26/memorandum-condemning-and-combating-racism-xenophobia- and-intolerance-against-asian-americans-and- pacific-islanders-in-the-united-states/;* E.O. 14012, 86 FR 8722 (2021); E.O.14031, 86 FR 29675 (2021); E.O. 14035, 86 FR 34593 (2021); E.O. 14041, 86 FR 50443 (2021); E.O.14045, 86 FR 51581 (2021); and other Presidential Actions.
[14] Cong. Rec. S1842 (daily ed. Mar. 23, 2010), *https://www.congress.gov/congressional-record/ 2010/03/23/senate-section/article/S1821-6.*
[15] 87 Fed. Reg. 47830.
[16] U.S. Dep't of Health & Human Servs., Office of Minority Health, Minority Population Profiles, *https://www.minorityhealth.hhs.gov/omh/*

[17] 87 Fed. Reg. 47830-47831

The NPRM here renders nonsensical the premises on which it rests. So if a physician recommends counselling a person of Filipino descent about hypertension, diabetes or obesity, and does not similarly take time to counsel other patients of non-Filipino Asian descent about these things, then by the non-discrimination tenets outlined in the NPRM, the physician has just discriminated on the basis of race in counselling. Similarly, if a physician increases screening for low birth weight in a Puerto Rican patient but does not screen as intensely in other Hispanic Latino patients, by the tenets of the NPRM, the physician has again just discriminated on the basis of race in the provision of health care. This renders the physician unable to exercise clinical judgement and the tailor both counselling and treatment to the needs of the patient. The comments in the NPRM on this issue are medically absurd.

"*Further, the disparities in maternal mortality rates are alarming. According to National Vital Statistics System data, in 2020, the maternal mortality rate for non-Hispanic/Latino Black women was 55.3 deaths per 100,000 live births, 2.9 times the rate for non-Hispanic/Latino white women (19.1).*[91] *This disparity is increasing, with maternal mortality rate increases between 2019 and 2020 for non-Hispanic/Latino Black and Hispanic/Latino people.*[92] *An analysis of vital statistics mortality data showing the cause of maternal deaths in the United States from 2016–2017 revealed maternal mortality for Black women largely resulted from conditions like preeclampsia and cardiomyopathy, and were believed to be preventable.*[93] *This study also found an increased risk of maternal mortality from multiple causes in Black women, which indicates negative impacts of structural racism on health and health care in the United States. The Biden-Harris Administration has taken initial steps to address these longstanding disparities, issuing the first-ever Presidential proclamation observing Black Maternal Health Week*[94] *and hosting the first-ever Federal ''Maternal Health Day of Action,'' which included a nationwide call to action to reduce mortality. The Administration has also announced several key policy actions, including CMS' intention to propose the first-ever hospital quality designation specifically focused on maternity care."*[18]

It is almost laughable that the NPRM suggests that creating a Maternal Health Day of Action will have any real effect on maternal mortality and the complex issues which underly this tragedy. The NPRM superficially identifies some issues which may pertain to maternal mortality but neglects the more substantial issue of subdividing maternal mortality by pregnancy outcomes. For example, in Finland, studies which have followed maternal deaths up to one year post pregnancy outcome demonstrate a clear increase in maternal mortality after elective abortion as compared to miscarriage, delivery or non-pregnancy.

It is also clear from CDC Abortion Surveillance data that abortion utilization among non-Hispanic/Latino Black women is approximately three times the rate as non-Hispanic White women, mirroring the threefold increase in maternal mortality. It is remarkable, given those statistics, that this discussion did not include pregnancy outcome specific mortality numbers. HHS must take abortion

[18] 87 Fed. Reg. 47831

utilization statistics, and all the data about the increased mortality after abortion into consideration in its proposal for any coherent plan to combat maternal mortality.

It is also clear that one of the stated and implied purposes of this proposed rule will be used to increase the total number of elective abortions especially with the focus on minority populations for access to elective abortion. AAPLOG requests answers to the following questions:

When the Department cries for "health equity", especially for an equity in elective abortion access which is racially equal, is the Department desiring an increased number of Caucasian preborn children to be killed in abortion, or a decreased number of Black preborn children to be killed in abortion?

What criteria will the Department use to determine when the abortion numbers are equitable?

Is the real abortion inequity the disparity between the two races or that one race is much more likely to be pressured into killing their children in the womb than the other?

It is remarkable then, that the proposed rule is aimed specifically at increasing elective abortion which would then increase the maternal mortality in the non-Hispanic Black population. This makes the rule arbitrary and capricious.

"*While research is beginning to reveal more information about the potential causes of Black maternal mortality, less research exists about the causes of maternal mortality among American Indian/Alaska Native women. A recent study documented the available literature on American Indian/Alaska Native women and found that the three leading causes of maternal mortality among such women are hemorrhage, cardiomyopathies, and hypertensive disorders of pregnancy.*[96] *The authors ultimately concluded that more research is needed to determine the root causes of maternal mortality among American Indian/Alaska Native women, but suggested that to reduce American Indian/Alaska Native maternal mortality and eliminate racial/ethnic disparities, provider-related factors including implicit bias must be addressed."* [19]

Again, here the NPRM pays lip service to the complex issue of maternal mortality, completely ignoring the studies both national and international which address underlying factors which have proven to be effective for reducing maternal mortality. In the Appendices to these comments is the AAPLOG Committee Opinion on Maternal Mortality quoted here:

Professional Ethics Committee of AAPLOG
Induced Abortion & the Increased Risk of Maternal Mortality

[19] 87 Fed. Reg. 47831

After years of failure to obtain accurate statistics on maternal mortality, the United States has noted a sharp increase in its maternal mortality rate, with widening racial and ethnic disparities. While some of this increase may be a result of improved data collection, pregnancy-related deaths are occurring at a higher rate in the United States than in other developed countries. In order to implement effective strategies to improve pregnancy outcomes, this must be investigated in an unbiased manner, and novel contributing factors need to be considered.

Background

A pregnancy question was added to the United States standard death certificate in 2003 in order to improve the identification of maternal deaths. The individual states were initially inconsistent in implementing a pregnancy checkbox on death certificates, rendering data so useless that the United States (U.S.) did not published an official maternal mortality report between 2007 and 2016.1 Using novel correction factors to standardize death certificate data, a 2016 report shocked the nation by documenting a 26 % increase in maternal mortality from 18.8/100,000 live births in 2000 to 23.8 in 2014. Suggested etiologies of the rise included: artifact as a result of improved maternal death surveillance,2 incorrect use of ICD-10 codes,3 health care disparities,4 lack of family support and other social barriers, substance abuse and violence,5 depression and suicide,6 inadequate preconception care, patient noncompliance, lack of standardized protocols for handling obstetric emergencies,7 failure to meet expected standards of care,8 aging of the pregnant patient cohort with associated increase in chronic diseases and cardiovascular complications,9 lack of a comprehensive national plan and defunding women's healthcare by "demonizing Planned Parenthood."10,11 State maternal mortality committee review committees suggested that 60 % of these deaths may be preventable.

Maternal Mortality Definitions

Deaths are categorized based on their causation and proximity to the end of the pregnancy:

• "Maternal death" is the death of a woman while pregnant or within 42 days of the end of her pregnancy, irrespective of the duration or site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, excluding accidental or incidental causes.

• "Late maternal death" is the death of a woman from direct or indirect obstetric causes more than 42 days, but within 365 days of the end of pregnancy.13

• "Pregnancy-related death" is the death of a woman while pregnant or within 365 days of the end of pregnancy, in which pregnancy may have contributed to the cause of the death.

• "Pregnancy-associated death" is the death of a woman while pregnant or within 365 days of the end of pregnancy from a cause that is either not related to pregnancy or pregnancyrelatedness cannot be determined.

The World Health Organization reports only deaths occurring during pregnancy or within 42 days of the end of pregnancy in defining maternal mortality while the Division of Reproductive Health at the Centers for Disease Control and Prevention (CDC) reports all pregnancy-related deaths occurring within one year of the end of pregnancy. Both report maternal mortality rate as the number of

maternal deaths/1000 women of reproductive age.

An ideal mortality rate would be achieved by calculating the number of maternal deaths/100,000 pregnancies. That is not feasible because the number of spontaneous pregnancy losses are difficult to record and induced abortion data is not shared. Since the number of live births can be accurately measured due to mandated reporting on birth certificates, epidemiologists assume that the number of live births is a good representation of the number of pregnancies. They developed a measure of disease known as the maternal mortality ratio and define it as the number of pregnancy-related deaths/100,000 live births. This is a mortality ratio, not a rate.

Similar to the total "number of pregnancies" needed in the denominator, the number of "pregnancy-related deaths" in the numerator is not known. Two out of three maternal deaths occur in conjunction with a live birth.16 The rest may be separated from the end of pregnancy by days, weeks or even months and includes spontaneous and induced end of pregnancy events. The U.S. does a poor job of accurately detecting maternal deaths, and studies show as many as 50 % of maternal deaths may be missed on death certificates.

Racial and ethnic disparity

Maternal mortality in minority women, particularly non-Hispanic Black women, has skyrocketed. Black women have maternal mortality rates 3.3 times higher than white women.20 Unfortunately, there have been accusations that this is a result of implicit racism held by health care providers – the care provided to Black or poor women is not as good as the care provided to non-Hispanic white women or affluent women. Limiting the discussion to implicit racism does a disservice to women of color and women in poverty by ignoring other factors that contribute to maternal mortality.

Poverty is certainly a risk factor for failure to obtain appropriate medical care and might be expected to contribute to the excess maternal mortality rates in Black women (20 % of whom live in poverty, compared to 16 % Hispanics and 8 % whites). Domestic violence and mental health disorders are also seen more commonly in impoverished communities. In 2011, Illinois reported that 13% of its maternal deaths were the result of homicide. Black mothers bore the greatest risk, accounting for 43% of the maternal homicide deaths while composing only 14% of the population. Texas has been noted to have extremely high maternal mortality rates, and an examination of deaths in 2011-2012 found that the overdoses, homicide and suicide accounted for almost 20% of the maternal deaths. Poverty and poor social and family support are causes of the disparity noted in maternal mortality rates.

Giving birth and caring for a child without a partner places a woman at an obvious disadvantage. She is more likely to live in poverty without the resources she may need to seek health care. If she should become ill during or after pregnancy, she may not seek emergency care due to lack of social support, child-care or transportation. It should be noted that only 5% of married couples live in poverty. In 2017, 67% of black women were unmarried when they gave birth to children, compared with 39% of Hispanic women, and 27% of white women. Prior to 1950, a black woman was more likely to be

married than a white woman, with marriage rates nearing 80%, but marriage rates for Black women have since plummeted. Could the breakdown of the Black family be a root cause of the disparity in maternal mortality rates?

It is noteworthy that there are significant differences in birth outcomes in Black women compared with non-Hispanic white women. The rates of natural losses are similar (16%), but 34% of pregnancies in black women end in induced abortion, compared to 11% for white women. Less than half of pregnancies in black women result in the birth of a live baby (48%). Induced abortion is 3.7 times more common in Black than in non-Hispanic white women, and Black women more commonly have later abortions (13%) compared with white women (9%). It is known that the risk of death increases by 38% for every week after eight weeks gestation. It is possible that the higher rate of legal induced abortion may account for most of the racial disparity noted in pregnancy mortality. Genetic determinants of health are important. For example, thrombophilia is more prevalent in nonHispanic Black women and this is a risk factor for pulmonary embolus or thrombotic strokes, both causes of maternal mortality. Social determinants of health are paramount: poverty is linked to obesity, diabetes and hypertension. Obesity is more prevalent in Black women (46.8 %) and Hispanic (47 %) than white women (37.9 %).29 Diabetes is higher in Black (12.7 %) and Hispanic (12.1 %) than in non-Hispanic white women (7.4 %).30 The rates of hypertension are higher among Black (40.4 %) compared to non-Hispanic white (27.4 %) or Hispanic women (26.1 %).31 If a woman is predisposed to hypertension, the likelihood that she will develop preeclampsia or eclampsia increases substantially. Obesity, diabetes and hypertension predispose women to early obstetrical interventions and Cesarean sections, both of which are linked to increased maternal mortality.

A ten-year Harvard study completed in 2016 found that implicit bias based on race decreased by 17 %, and explicit bias decreased by 37 %.32 If racial bias reported in the Harvard study was the sole cause of maternal mortality, pregnancy-related mortality in the non-Hispanic Black community should have decreased. It has not. To discuss the effects of years of legalized racism without identifying antecedent enslavement is implicit bias and it promotes the idea that Black and non-Black women start on an equal playing field. It confirms the stereotype that Black women, through their reckless behavior, place themselves far behind the rest of the population. Victim-blaming subtly diverts attention from racism, discrimination, segregation and the powerlessness of the ghetto. Victim-blaming leads to inappropriate adventures, such as placing abortuaries in Black neighborhoods. Abortionists are like carpetbaggers, nonresidents seeking gain by taking advantage of communities of color. Compounding structural inequality, abortion advocates effectively perpetuate Jim Crow era suppression.

The effects of family disruption by enslavement's forced displacement followed by a long history of voluntary migration due to legalized racism are still apparent in the separation of family units, structural inequality and the resultant high prevalence of poverty. Poverty is a cause of physical disease, emotional stress and mental health distress. Victim-blaming abortion advocacy organizations have a long history of targeting minority communities. Inflicting abortion, often in advanced pregnancy, is documented to lead to increased risk-taking behavior that results in death from drug

overdose, suicide or homicide. Induced abortion may be a root cause of the racial and ethnic pregnancy-related mortality disparity. Addressing contextual-level social determinants of health could eliminate this disparity.

Determining pregnancy-related deaths

The Centers for Disease Control and Prevention (CDC) relies heavily on death certificates to determine maternal deaths, but death certificates have been proven unreliable in accurately identifying all maternal deaths. Deaths due to live births are likely to be the most accurately recorded because most live births occur in a hospital setting or with the assistance of medical personnel. However, deaths from other pregnancy outcomes such as induced abortion are not accurately reported. Information about abortion is often not recorded on death certificates for women of reproductive age. Inconsistent implementation of a pregnancy checkbox on death certificates and search engine failures to provide ICD-10 obstetric-specific codes for abortion-related deaths thwart this documentation. For example, the Texas Maternal Mortality Task Force discovered that more than 50 % of the maternal deaths identified by ICD-10 obstetric codes showed no evidence of pregnancy and another 10 % had insufficient information to determine whether a pregnancy had occurred.37 Either these deaths were erroneously coded as pregnancy-related, or the deaths were subsequent to spontaneous or induced losses early in pregnancy and not able to be correlated with fetal birth or fetal death certificates. Independent providers perform almost all abortions in Texas and these records are not be available. In Finland 73 % of maternal deaths were not identified on death certificates, demonstrating the clear inadequacy of death certificate data alone. The quality of U.S. pregnancy-related mortality data is poor.

Determining induced-abortion deaths

Published abortion mortality rates are inaccurate because the total number of legal abortions performed in the U.S. is not known. Estimated numbers of abortions are voluntarily reported to the CDC by state health departments. California, the state with the largest volume, does not report any data. The Guttmacher Institute also tracks these numbers, and it consistently reports higher numbers than the CDC. For example, the CDC reported 652,639 abortions in 2014 while the Guttmacher Institute reported 926,000.41,42 Twenty-seven states require abortion providers to report complications but there are no enforcement penalties for noncompliance. Only 12 states require coroners, emergency rooms and other health care providers to report abortion-related complications or deaths for investigation.

If an abortion initiates a cascade of events resulting in death, only the closest antecedent events may be listed on the death certificate due to space limitations and provider time constraints. Since most abortion providers lack hospital-admitting privileges, other health care providers are required to provide hospital care. The physician certifying the death may be unaware of the abortion or mistakenly believe that a miscarriage led to the complications. Furthermore, ideological commitments may lead a certifier to omit this information. Due to the social stigma surrounding abortion, families of women dying from complications are unlikely to initiate malpractice lawsuits.

Correlating public documentation of malpractice cases with autopsy reports, an investigative reporter was able to document 30 % more abortion-related deaths nationwide than the CDC. The reported death rate from abortion represents only the tip of the iceberg, a problem much larger than it appears. There has been widespread misinformation about abortion. It seems as if deaths rarely occur and abortion is perceived to be a very safe procedure. When discussing maternal and induced abortion-related mortality, consideration is often given only to complications that can occur in a term, gravid uterus rather than recognizing that physiologic changes begin as soon as a pregnancy commences. Induced abortion interrupts this normal physiology and there are unique risks due to this intervention. Historically, surgical dilation and sharp curettage (utilizing a sharp curette rather than a suction catheter) had been used in the first trimester of pregnancy, but this more frequently resulted in uterine trauma.

Significant complications may occur with a surgical abortion, so it is not surprising that women opt to have mifepristone-induced pregnancy terminations (medical abortions) performed instead. Accounting for 31 % of U.S. abortions, medical abortions are performed until 10 weeks gestation by administering mifepristone and misoprostol. A medical abortion disrupts hormones that maintain the pregnancy and cause uterine contractions that eventually expel the baby and the placenta. Yet, most women are unaware that the complication rate is four times higher with this procedure than with surgical abortion. The most common complication is hemorrhage with almost 8 % of women experiencing incomplete abortions requiring surgical completion. Other serious complications of medical abortions include uterine perforation (0.2-0.5 %) and uterine rupture (0.28 %) in women who have had prior Cesarean sections. Animal models of medical abortion warn of the potential for long-term negative well-being indicative of depression and anxiety. Both mifepristone and misoprostol disrupt innate immunity and fatal cases of septic shock following medical abortion have occurred. In 2003, 40 % of legal induced abortion deaths occurred following medical abortions.
Beginning in the second trimester, dilation and evacuation (D&E) is the surgical method necessary because the pre-born baby has grown large enough that it cannot be removed through a suction cannula. The risks of D&E abortions include hemorrhage and cervical laceration (3.3%) and retained body parts and/or placental tissue (1 %). Non-intact D&E (9 %) is commonly referred to as a "dismemberment" abortion because the pre-born baby is removed in a piecemeal fashion with instruments. Intact D&E, also known as dilation and extraction (D&X) or "partial birth" abortion, has been illegal in the U.S. since 2003. During that procedure the pre-born baby's feet first appear which the abortionist grabs and pulls until the body delivers. Once the bottom of the baby's head is exposed, the abortionist evacuates its brain with a vacuum causing its large skull to collapse which finally enable delivery. The increased size of the pre-born baby and increased amount of placental tissue requires a greater degree of cervical dilation while the thin relaxed uterine myometrium is more likely subject to mechanical perforation and resulting catastrophic hemorrhage.
Historically, saline or prostaglandin was infused into the amniotic sac in late-term abortions to kill the pre-born baby and induce labor. Maternal deaths occurred due to fluid imbalances and infections. Hysterotomy abortion (performing a Cesarean section to complete a late-term abortion) is rarely used because it is a major surgical procedure.

Labor induction is the method used to perform extreme late-term abortions. Labor-induction abortions are often complicated by immediate maternal hemorrhage, requiring an invasive surgical procedure to extract retained placental tissue. A large European study documented that more than half of the babies survived delivery in post-viability induced abortions. If a baby is born alive, the abortionist may complete the abortion by performing active or passive infanticide. Many abortionists perform feticide via intracardiac or intra-amniotic injections to avoid this dreaded complication.

Severe physical injuries occur from surgical abortion. Experienced abortionists not infrequently damage adjacent organs or major blood vessels as they insert suction curettes or grasping forceps into the soft, gravid uterus. Injury to adjacent major blood vessels and/or gynecologic, genitourinary or gastrointestinal organs requires emergency abdominal surgical exploration to perform a hysterectomy, bowel resection, bladder repair, or other repair. Death from induced abortion can occur due to vaginal and intra-abdominal hemorrhage, sepsis, thrombotic emboli, intravascular amniotic or air emboli, complications of anesthesia and cardiac or cerebrovascular events. Forcibly opening a cervix that is designed to remain closed until natural childbirth may result in cervical trauma and cervical incompetence in future pregnancies. This weakened cervix may dilate early in a subsequent pregnancy, predisposing the woman to premature rupture of membranes, intrauterine infections and possible sepsis. Statistically significant studies show a connection with preterm birth. One meta-analysis found that there was a 25 % increased risk of premature birth in a subsequent pregnancy after one abortion, 32 % after more than one, and 51 % after more than two abortions. Another meta-analysis found a 35 % increased risk of delivery of a very low birth weight infant after one abortion, and 72 % after two or more abortions. Obstetrical interventions for the management of preterm birth raise the risk of maternal mortality.

Instrumental trauma to the endometrium may result in faulty placentation in subsequent pregnancies. The Placenta Accreta Spectrum (PAS) is abnormal placentation in which the placenta invades into the cervix, uterine wall, or other adjacent organs; it includes placenta accreta, placenta increta and placenta percreta. In 1950 the incidence of PAS was 1:30,000 deliveries but in 2016 the incidence was reported to be 1:272 deliveries. This 110-fold increase in incidence raises the risk of pregnancy-related mortality, occurring in women with a history of uterine surgery, including induced abortion. PAS can cause massive hemorrhage. Deaths occur even in high-level hospitals, and the fortunate survivors often require transfusion of scores of units of blood to save their lives.

The frequency of abortion complications increases as the pregnancy advances due to greater technical complexity related to the anatomical and physiologic changes that occur. Compared to early abortions, the relative risk of death was 76.6 times higher beyond 21 weeks (rate 8.9/100,000). It is known that the risk of death from abortion increases by 38 % for each additional week beyond 8 weeks.The American Board of Medical Specialties recognizes the inherent danger of late-term abortions. In 2018 it approved the new American Board of Obstetrics & Gynecology subspecialty “Complex Family Planning” to train abortionists to perform late-term abortions.

In addition to the immediate physical risks to a woman from an abortion, there are long-term complications that increase a woman's risk of death. Stress accompanying voluntary or spontaneous pregnancy loss may adversely impact a woman's health and wellness. Delivering a baby may have a protective emotional effect whereas induced abortion may have a deleterious emotional effect. A large meta-analysis found that women experienced an 81 % increased risk of mental health problems after induced abortions: 34 % increased risk of anxiety, 37 % increased depression, 110 % increased alcohol abuse, 230 % increased marijuana abuse, and 155 % increased suicidal behavior. An eight-year retrospective study showed that those who aborted had significantly higher age-adjusted risks of death from suicide (254 %) compared to those who delivered a baby. A comprehensive record linkage study from Finland found that following an abortion, a woman was two to three times as likely to die within a year, six times as likely to commit suicide, four times as likely to die from an accident, and fourteen times as likely to be murdered, compared with a woman who carried to term.

Finnish studies also revealed that the risk of death from abortion (101 deaths per 100,000 ended pregnancies) was almost four times greater than the risk of death from childbirth (27 deaths per 100,000 ended pregnancies). Mental health issues may contribute to drug overdoses, suicides, homicides or even accidents due to risk-taking behavior, but our current system of data collection is not capable of linking these events to induced abortion.

Due to the paucity of complication data available in the U.S., the actual abortion-related mortality rate is undoubtedly much higher than reported. Legal or ideological motivation can obscure the initiating event that led to death. In addition, the failure of most abortion providers to maintain hospital privileges forces a different hospital-based health care provider to treat the resulting complications. It is not possible to link deaths related to early pregnancy events to an infant's birth or death certificate. Even in Finland, a country with single payer healthcare and exceptional data linkage, 94 % of abortion-related deaths are not identified on death certificates. Due to restricted data access, poor record keeping and lack of mandatory complication reporting, the actual induced abortion-related mortality rate in the U.S. cannot be determined.

Report of the National Academies of Science, Engineering and Medicine (NAS)

In spite of these documented risks of abortion-related mortality, the NAS published a book that stated that induced abortion is extremely safe. They concluded that serious complications or long-term physical or mental health effects are virtually non-existent; specifically they denied that abortion increases the risk of preterm delivery or mental health disorders. They did not consider the increased risk of hemorrhage due to PAS that can occur with subsequent pregnancies. Abortion is so safe, they wrote, that it does not need to be performed by physicians. Trained midlevel practitioners can perform abortions in an office-based setting via telemedicine without the need for hospital admitting privileges, special equipment or protocols for emergency transport of women with complications. They wrote that the only risks associated with abortion are the imposition of "barriers to safe and

effective care" by some state legislatures.

Selection bias against the existence of delayed morbidity is obvious in the literature chosen by the NAS. A meta-analysis revealed a curious lack of interest by most investigators in the question of whether abortion is safer than childbirth. They purposefully excluded the eleven studies that provided results allowing comparison between the death rates associated with all possible pregnancy outcomes. These studies showed that the risk of death within 180 days is over twice as high following abortion compared to delivery and this risk remains elevated for at least ten years. Compared with those who delivered a baby, those who underwent induced abortion had significantly higher age-adjusted risks of death from all causes (162 %), from suicide (254 %), as well as from natural causes (144 %). The risk of death in a given year for a woman who was not pregnant was 57/100,000 women, but after an abortion the risk was 83/100,000, after miscarriage 52/100,000, and for those who carried a pregnancy to term 28/100,000.

Danish studies reported that the risk of death within 180 days after a first trimester abortion was 244 % higher than the risk of death after childbirth; the risk of death after a late term abortion was 615 % higher than that after childbirth. Stringent selection criteria allowed the NAS to disqualify these and other valid reports due to "study defects." For immediate morbidity, they allowed abortionists to control the dialogue by only discussing reports authored by them or their aligned organizations. This is known as "incestuous citing," allowing abortionists to cite each other to prove their points. In California, Planned Parenthood aborts an alarming number and 317,000 of these abortions were reviewed. Severe complications and deaths, particularly from nonaligned late-term abortion providers, have been reported in the media. The refusal of California to report and the paucity of voluntary reporting nationwide yield the outcome that abortion advocates demand: most abortion complications are never identified. The NAS was aware of its selection bias and should have made a call for more studies, not a categorical dismissal that abortion complications are nonexistent.

Abortion v childbirth, safety

Epidemiologists define the abortion mortality rate as the number of induced abortion-procedure deaths/100,000 induced abortions. There are many pregnancy events that may result in mortality that are excluded from the denominator "100,000 induced abortions." If abortion-procedure deaths were erroneously or intentionally classified as pregnancy-related maternal deaths, this would inflate the maternal mortality ratio and decrease the abortion mortality rate. For example, a death from an induced abortion following intentional feticide could be coded as a death caused by a procedure to evacuate an intrauterine fetal demise. The abortion death rate must be higher than published because deaths from abortion are underreported and the numbers of abortions are inflated.

A widely reported study concluded that abortion was 14 times safer than childbirth. Abortion advocates even argue that since childbirth is so dangerous, abortion should be readily available so women can "opt out" of being pregnant. Is abortion really safer than childbirth? Abortion-related deaths were compared to the number of legal abortions, whereas pregnancy deaths were compared to

the number of live births. One cannot compare the abortion-related mortality rate to the pregnancy-related mortality ratio – this is meaningless exercise. Of the four variables used in the abortion-related mortality rate and the pregnancy-related mortality ratio, the number of live births is only variable that can be accurately determined. The study used three impossible-to-quantify variables to compare two disparate outcomes: a false equivalence.

Finland has universal health and data linkage allowing it to use "ended pregnancies" as a common denominator when studying abortion-related v childbirth-related mortality. They reported that the risk of death from abortion (101 deaths per 100,000 ended pregnancies) was almost four times greater than the risk of death from childbirth (27 deaths per 100,000 ended pregnancies).
This data is not available in the U.S. so one must implement different methodology to compare outcome-specific rates of abortion-related and childbirth-related mortality. Since abortion and most childbirth deliveries are done vaginally and since abortion may increase the percent of women undergoing Cesarean section in subsequent pregnancies due to preterm birth and abnormal placentation, Cesarean deliveries should be excluded when comparing the safety of childbirth and abortion. To make a valid comparison, an outcome-specific rate for maternal mortality must be used: mortality associated with vaginal childbirth. The vaginal delivery maternal mortality rate is calculated as the number of vaginal-childbirth-maternal deaths/100,000 vaginal deliveries. Using outcome-specific rates, the mortality rate for vaginal delivery is 3.6 deaths/100,000 vaginal deliveries, while the rate for abortion performed at 18 weeks or later is 7.4 deaths/100,000 abortions. Put another way, the risk of death from these abortions is more than double that for women who deliver vaginally.

Recommendations:
1. Advocate for better data collection, especially correlating current outcomes and historic early pregnancy events. Since the risk of death within 180 days of the end of pregnancy is over twice as high following induced abortion compared to childbirth, death certifiers must document early pregnancy events in order to increase the accuracy of mortality data. Access to study all deaths occurring within one year of the end of pregnancy will allow unbiased researchers to correlate current pregnancy outcome with early pregnancy and prior pregnancy adverse events, including legal induced abortion.
2. Enforce mandatory reporting of abortion complications and abortion-related deaths, with strict noncompliance penalties, to improve data collection and more accurately reflect abortion-related deaths.
3. Direct attention to the association of legal induced abortion with subsequent pregnancy complications requiring obstetrical interventions that increase risk of maternal mortality – sepsis and catastrophic hemorrhage.
4. Raise awareness that induced abortion is also associated with very preterm deliveries in subsequent pregnancies, forcing obstetrical interventions that could increase the risk of maternal mortality.
5. Be aware that a woman's mental health status following legal induced abortion may be associated

with increased risk-taking behavior leading to becoming a victim of homicide, suicide or drug overdose.
6. Encourage additional research of the abortion-linked complications that have not been inadequately studied, such as the abortion and breast cancer link.
7. Consider social determinants of health disparities, particularly as they contribute to the increased mortality of ethnic/racial minority mothers. Particular emphasis should be given to encouraging paternal engagement and increasing familial support.

Conclusion

Biased academic physicians have led the discussion on maternal mortality. Having economic ties to the abortion industry, these elite abortion advocates publish articles that document "safety" for an industry that profits from widespread abortion access. To increase their credibility, each one quotes the others' poor data. Journal editors frequently have conflicts of interest,97 and readers are not assured that independent reviewers have critically evaluated submissions by academic abortion advocates before publication. People were not content to blindly believe the tobacco industry when reassured that smoking was safe and did not cause cancer. People must refuse to be deluded by the abortion industry as it protects its product by reassuring that abortion is safe, an assertion based on deliberately deceitful and inadequate data. The politics of pregnancy-related mortality and induced abortion must not be allowed to continue to obstruct root cause analyses of maternal mortality.

"Health Equity and Discrimination Related to Sex

Disparities in women's health are well-documented. For example, although heart disease is the leading cause of death for men and women in the United States, women are more likely to experience delays in emergency care and treatment to control their cholesterol levels.[114] Women are also more likely than men to die from a heart attack.[115] The delay in the diagnosis and treatment of heart disease is just one of many disparities women experience in health care settings. Some evidence suggests that women treated by male physicians for heart attacks experience higher rates of mortality compared to women treated by a female physician or by a male physician who has had more exposure to female patients and female physicians.[116]

Studies regarding pain management have also indicated the risk of gender bias, based on the notion that men and women are ''separate and different in manners and needs,'' with a review of the literature revealing studies that show women receive less adequate pain medication, more antidepressants, and more mental health referrals compared to men.[117] Studies indicate this may have to do with erroneous gender stereotypes that men are ''stoic, in control, and avoid[] seeking health care,'' whereas women are presented as ''more sensitive to pain and more willing to show and to report pain'' compared to men.[118]

LGBTQI+ individuals in the United States also face pervasive health disparities and barriers in accessing needed health care. Throughout this preamble, we will use the full acronym of LGBTQI+ when talking broadly about individuals who are LGBTQI+ but will use a subset of the acronym (e.g., ''LGB,'' ''LGBT'' or ''LGBTQ'') when discussing studies, research, or concepts that apply only to a subset of this group.

Overall, LGBTQI+ individuals report being in poorer health than non- LGBTQI+ individuals. LGBTQ+ individuals, moreover, are at increased risk for or are particularly affected by certain health conditions, including sexually transmitted infections,[119] Human Immunodeficiency Virus (HIV),[120] obesity,[121] conditions associated with tobacco, alcohol, and other substance use,[122] and mental health conditions,[20] including suicidality.[21] "[22]

Although the proposed rule goes through a litany of findings of different health outcomes of different sexes and gender identities, the document does not provide any evidence as to how discrimination related to termination of pregnancy is in any way involved in any of this litany of alleged negative health outcomes. The inclusion of termination of pregnancy in the definition of sex discrimination does not in any way affect any of these disparities and it is thus arbitrary and capricious to include it .

This illustrates an ongoing theme throughout the NPRM which is that the problems identified are completely unrelated either rationally or scientifically to the changes the NPRM proposes to make. Through this rhetorical technique the NPRM raises compassion for problems which need to be addressed, but those problems are not either rationally or scientifically addressed in the actual changes that the NPRM proposes. and in fact distract from the actual content and implications of the proposed rules. **How does the Department support the assertion that inclusion of elective abortion in the term "discrimination on the basis of sex" change any of the litany of problems** *including sexually transmitted infections,[119] Human Immunodeficiency Virus (HIV),[120] obesity,[121] conditions associated with tobacco, alcohol, and other substance use,[122] and mental health conditions,[23] including suicidality.[24]* **cited above?**

The short answer is, it can't.

Improving the Nation's Health Through Civil Rights Protections
The Department is committed to doing its part to address health disparities and to promote equity in health care access through a range of initiatives, including through implementation and enforcement of Section 1557's protections. As reviewed above, the 2016 Rule provided clarity regarding Section 1557's strong statutory protections from discrimination and equipped the Department with the means to enforce these protections. The 2020 Rule, by contrast, limited the Rule's scope, removed principal provisions from the Section 1557 regulation, and left ambiguity regarding the extent of various protections. The 2020 Rule removed specific provisions implementing nondiscrimination protections

---

20 Charlotte Patterson et al., Nat'l Acads. of Sci., Eng'g, & Med., Understanding the Well-Being of LGBTQI+ Populations, p. 298 (2020), *https:// doi.org/10.17226/25877*.

21 Daniel, *supra* note 119.

22 87 Fed. Reg. 47832-4834

23 Charlotte Patterson et al., Nat'l Acads. of Sci., Eng'g, & Med., Understanding the Well-Being of LGBTQI+ Populations, p. 298 (2020), *https:// doi.org/10.17226/25877*.

24 Daniel, *supra* note 119.

regarding gender identity. The 2020 Rule also eliminated specific provisions addressing discrimination in health insurance coverage benefit design and eliminated provisions designed to ensure access to language assistance services for LEP individuals. Furthermore, 2020 Rule also narrowed the regulation's application to some, but not all, operations of health insurance issuers and to only certain programs administered by the Department.
The 2020 Rule's removal of specific nondiscrimination provisions from the Section 1557 regulation—including the provision implementing protections based on gender identity discrimination, as well as other changes that could be read to limit the reach of Section 1557— has the potential to increase the incidence of discrimination for groups protected under the statute. As described above, discrimination leads to negative impacts on access to care and mental and physical health outcomes. An increase in discrimination will widen existing disparities and harm the well-being of underserved and historically marginalized individuals and communities. The Department acknowledges the potential interest that covered entities and other stakeholders may have in maintaining the 2020 Rule and recognizes that some of the proposed revisions reflect changes to certain positions articulated in that Rule. Howeverthe Department is also cognizant of the fact that absent revisions to the 2020 Rule, protected groups likely will be relegated to inferior health care access without strong civil rights protections at a moment when health disparities have been magnified by the unequal burden of the COVID–19 pandemic. "[25]

Without any scientific justification whatsoever, and with simply bold-faced assertion of claims, the Department attempts to justify its own kind of discrimination on the basis of sex by using the NPRM to wipe out both conscience protections and abortion neutrality protections contained in the 2020 rule. This is arbitrary and capricous. **The Department fails to cite any evidence to support that ignoring federal conscience protections will improve the health care of anyone.**

In fact, AAPLOG members, who have conscientious objection to elective abortions, provide a large percentage of health care in underserved areas. Forcing conscientious health care professionals out of the practice of medicine, such as the many AAPLOG members, will increase maternity care deserts across the country and increase the health disparities, especially for those in underserved areas, even more that those which currently exist. The NPRM will inflict *irrevocable* harm on physicians who practice Hippocratic medicine and who thus refuse to participate in killing their preborn patients through elective abortion.

The Department gives no scientific or rational justification for this wholesale discrimination against physicians of conscience who do not agree to kill their preborn patients. Instead, the Department through this NPRM will force Hippocratic physicians out of practice, punishing them with crippling fines and accusations of "sex discrimination". This harms not only physicians, but also patients who will lose their phsycian or choice or access to physicians in general, leading to worse health outcomes. Ironically, this NPRM will perpetuate the very harm it decries and purports to address.

[25] 87 Fed. Reg. 47836-4837

Application (§92.2)

Proposed §92.2 addresses the application of this regulation. The Department proposes in §92.2(a) to apply the rule, except as otherwise provided in this part, to: (1) every health program or activity, any part of which receives Federal financial assistance, directly or indirectly, from the Department; (2) every health program or activity administered by the Department; and (3) every program or activity administered by a Title I entity. Paragraph (a)(1) proposes to make the rule applicable to every health program or activity, any part of which receives Federal financial assistance, directly or indirectly, from the Department.

... We seek comment on the implications of this scope; the implications of applying a Section 1557 implementing regulation broadly to all programs and activities of the Department; and, if the Department were to do so, if that should be done through a separate regulation, similar to the Department's Section 504 implementing regulation that applies to programs and activities conducted by the Department at 45 CFR part 85.[26]

This section will apply the NPRM practically to all healthcare entities under the proposal above. Thus not only will physicians who practice according to the Hippocratic Oath be banned from practice but likewise so will any faith-based health care entity which refuses to participate in ending the life of preborn patients. This proposed rule is a massive overreach of the Department into every sphere of medical practice, in order to force compliance with a politically driven agenda which forces the participation of all health care entities and all health care professionals in ending the lives of human beings in the womb. This is an overreach which was specifically prohibited in previous rules cited by this NPRM but which this Department has chosen to ignore, thus setting this Department not only above the law but also above any doctor-patient relationship. This is arbitrary and capricious behavior on the part of the Department, which is well illustrated in the subsequent section of the NPRM on Title IX Exceptions:

Treatment of Title IX Exceptions

"As discussed further below, the Department also believes that in order to construe particular terms in (or incorporated by) Section 1557, such as the meaning of ''sex'' or ''disability''; what it means to be ''subjected to discrimination'' on one of the specified grounds; the scope of ''program or activity''; and what counts as ''Federal financial assistance,'' it is reasonable and appropriate to look to how Congress, the agencies, and the courts have construed those terms under Title VI, Title IX, the Age Act, and Section 504. There is no similar basis, however, for concluding that Congress incorporated into Section 1557 any of the exceptions that Congress added to Title IX—the only one of the four statutes referenced by Section 1557 that contains such exceptions, and also the only statute with jurisdiction that is limited to a certain type of program or activity (i.e., education programs or activities). At the very

[26] 87 Fed. Reg. 47837

least, Section 1557 does not unambiguously require HHS to incorporate any of the Title IX exceptions into its regulatory scheme.[2728] ‘‘[29]

Incoherently, the Department states " *it is reasonable and appropriate to look to how Congress, the agencies, and the courts have construed those terms under Title VI, Title IX, the Age Act, and Section 504"* then immediately after refuses to look at the exceptions that Congress incorporated. "*There is no similar basis, however, for concluding that Congress incorporated into Section 1557 any of the exceptions that Congress added to Title IX—the only one of the four statutes referenced by Section 1557 that contains such exceptions, and also the only statute with jurisdiction that is limited to a certain type of program or activity (i.e., education programs or activities). At the very least, Section 1557 does not unambiguously require HHS to incorporate any of the Title IX exceptions into its regulatory scheme.*[3031] ‘‘[32]

Essentially the Department is saying that it has the authority to pick and choose what it wants to follow of that which Congress has explicitly stated, so long as what Congress states agrees with what the Department wants to do. But where Congress explicitly forbids what the Department wants to do, the Department claims that they do not have to obey Congressional authority. This is arbitrary and capricious and contrary to law.

By what authority does the Department ignore what Congress has clearly stated in the exceptions to the rules this proposed rule cites?

"This NPRM proposes not to import any of the Title IX exceptions into the Section 1557 regulation because the statutory language of Section 1557 is best interpreted to not authorize, and at the very least not command, the Secretary to promulgate such an extension of the Title IX exceptions." [33]
The Department categorically refuses to recognize not only Congressional oversight and authority, but also court authority when the Department refuses to import Title IX exceptions:

---

[27] To the degree that there is any statutory ambiguity, the Department has discretion as to whether and how to incorporate other aspects of the referenced statutes. *See Chevron, U.S.A., Inc.* v. *Nat. Res. Def. Council, Inc.*, 467 U.S. 837 (1984) (courts should give ‘‘considerable weight to an executive department’s construction of a statutory scheme it is entrusted to administer, and the principle of deference to administrative interpretations, ‘has been consistently followed whenever a decision as to the meaning or reach of a statute has involved reconciling conflicting policies, and a full understanding of the force of the statutory policy in the given situation has depended upon more than ordinary knowledge respecting the matters subjected to agency regulations’’’).

[28] U.S.C. 1681(a)(4).

[29] 87 Fed. Reg. 47837

[30] To the degree that there is any statutory ambiguity, the Department has discretion as to whether and how to incorporate other aspects of the referenced statutes. *See Chevron, U.S.A., Inc.* v. *Nat. Res. Def. Council, Inc.*, 467 U.S. 837 (1984) (courts should give ‘‘considerable weight to an executive department’s construction of a statutory scheme it is entrusted to administer, and the principle of deference to administrative interpretations, ‘has been consistently followed whenever a decision as to the meaning or reach of a statute has involved reconciling conflicting policies, and a full understanding of the force of the statutory policy in the given situation has depended upon more than ordinary knowledge respecting the matters subjected to agency regulations’’’).

[31] U.S.C. 1681(a)(4).

[32] 87 Fed. Reg. 47837

[33] 87 Fed. Reg. 47838

The district court in *Franciscan Alliance* read the term ''ground'' to necessarily incorporate not only the prohibited basis for discrimination—*i.e.*, sex—but also any exceptions set forth in Title IX.[207] The Department believes that, as a textual matter, the more natural understanding of ''ground prohibited'' is that it refers simply to the basis on which discrimination is prohibited. Further, subsection (b) of Section 1557 refers to ''discrimination on any *basis* described in subsection (a),'' which suggests that ''ground'' in subsection (a) means the ''basis'' for discrimination, *i.e.*, race, color, national origin, sex, age, and disability.[208]"[34]

Thus, because the Department does not like the conclusions of the *Franciscan Alliance* court, the Department refuses to submit to either court or Congressional oversight, arrogating to itself the power to decide what laws and rules it will or will not comply with. This action is not within the legal bounds of the Department and illustrates the arbitrary and capricious nature of this NPRM. The NPRM is refusing to seriously recognize in this rule any conscience or RFRA based claims. This NPRM clearly attempts to force elective abortion on medical professionals who do not want to kill the human being in the womb who is their second patient. Forcing medical professionals to go against their conscience and kill their second patient is a clear violation of the exercise of conscience and religious freedom which Congress specifically forbade when creating the exceptions to Title IX.

The Department goes on to demonstrate that one of the express purposes of this NPRM is to force both health care professionals and faith-based institutions to perform elective abortions with no conscience exceptions.

Moreover, the application of the Title IX exception for entities controlled by religious organizations, in particular, could raise distinctive concerns in the health care context that are not typically present in education programs and activities…. Incorporation of Title IX's religious exception would therefore seriously compromise Congress's principal objective in the ACA of increasing access to health care. [35]

The religious exception being referred to in this section is an exception from being forced to provide or pay for elective abortions. Thus in this NPRM the Department is clearly seeking to force faith based and religious institutions to participate in and pay for the elective killing of preborn human beings. Disingenuously, the department then goes on to claim: *"While not incorporating the Title IX religious exception, the Department is fully committed to respecting conscience and religious freedom laws when applying this rule, including an organization's assertion that the provisions of this rule conflict with their rights under Federal conscience and religious freedom laws as addressed in proposed §92.302."*[36]

If there is no religious exception then the words "*the Department is fully committed to respecting conscience and religious freedom law"* is completely deceptive. If the department intended to respect

[34] 87 Fed. Reg. 47838
[35] 87 Fed. Reg. 47839
[36] 87 Fed. Reg. 47839

religious freedom, the simplest and most straightforward way do so would be to incorporate existing exceptions from Title IX as required by the text of Section 1557.

The Department is also fully well aware that the current federal conscience protection laws in fact **depend on the Department itself to enforce**, as none of the current federal conscience protection laws have a private right of action. The existing laws are insufficient to protect anyone or any entity's conscience on the issue of elective abortion, as none of the statutory conscience protections allow for the person or entity to sue, but instead depend on HHS to issue an agency enforcement action against the affecting entity or sue on behalf of the person or entity to protect their conscience rights, a position which HHS, as clearly stated in this document, refuses to protect and in fact has shown blatant disregard for under this administration.

Some examples of HHS's refusal to protect conscience rights are captured in this recent article[37] quoted here:

1. *Dismantling HHS's Conscience and Religious Freedom Division*

One of Becerra's early acts as secretary was to strip the Conscience and Religious Freedom Division within the HHS Office for Civil Rights (OCR) of its independent ability to investigate violations of conscience and religious freedom laws. The division was created during the Trump administration to guarantee enforcement rather than neglect of laws that protect these fundamental and inalienable rights.

Becerra's first budget proposal would have effectively eliminated this division as a standalone entity, despite Becerra having promised Congress that "the work [of the Conscience and Religious Freedom Division] will not change." He, along with OCR political staff (such as political ideologue Laura Durso), refused to even consult with the dedicated career professionals of the division while they methodically removed conscience and religious freedom protections from the American people.

These developments were foreshadowed by transgender activist Dr. Rachel Levine who, prior to being elevated to the number-three position at HHS, proclaimed the division should be "either disbanded or certainly redirected."

2. Removing OCR's First Amendment Enforcement Power

Becerra removed OCR's authority to enforce conscience and religious projections under the bipartisan Religious Freedom Restoration Act (RFRA) and the First Amendment. A leaked memo revealed this move came at the request of Lisa Pino, the Biden-appointed director of OCR. She is tasked with enforcing civil rights protections in health and human services, not finding ways to remove them.

Remember, it was HHS under Obama that went after the Little Sisters of the Poor and lost under RFRA. Now Becerra has removed the only internal entity that would hold HHS accountable to the law.

[37] https://thefederalist.com/2022/03/18/in-its-first-year-bidens-hhs-relentlessly-attacked-christians-and-unborn-babies/

3. Pushing a Ridiculously 'Woke' Budget

The Biden-Becerra HHS budget for fiscal year 2022 removed references to "conscience," "religion," and "Conscience and Religious Freedom Division." But don't worry, the new budget replaces references to these constitutional and statutory rights HHS is responsible for enforcing with a bunch of woke terms like "equity" — the Biden administration's preferred priority.

4. Backing Forcing Nuns to Pay for Abortion

While Becerra was attorney general of California before becoming HHS secretary, OCR issued two notices of violation against Becerra and his state for violating federal conscience protections by forcing nuns (and others) to provide insurance coverage of abortion. Apart from the clear conflict of interest with Becerra leading the very office that previously found him in violation of the law, OCR under Becerra "reassessed" the conscience violations, magically finding there were none.

5. Abandoning Nurse Illegally Forced to Participate in Abortion

In 2019, OCR found a hospital had violated a nurse's conscience rights by forcing her to participate in an abortion over her known conscience objection. When the hospital refused to change its policies to comply with the law, the federal government sued the hospital in federal court.

But on Becerra's watch and despite his many promises to continue enforcing federal conscience laws, the Biden administration quietly dismissed the case without any settlement, agreement, or compensation for the nurse. Because federal conscience protection laws do not provide a private right of action, she cannot sue on her own and the violating hospital has been let off with impunity.

6. Relentlessly Pushing Abortion With Federal Resources

In response to Texas' law protecting unborn children with beating hearts from abortion, the Biden-Becerra HHS announced, despite prohibitions on federal funds going to abortion, ways the department could "bolster access to safe and legal abortions in Texas." HHS is awarding $10 million in additional funding to increase access to abortifacients for those affected by the Texas law.

OCR issued pro-abortion guidance explaining how a federal conscience protection law can protect abortion providers and patients seeking abortions. If HHS's actions weren't clear enough, Becerra stated, "We are telling doctors and others involved in the provision of abortion care, that we have your back." Becerra and OCR clearly don't want to enforce the law for those who do not want to participate in abortion.

7. Directly Funding Big Abortion

Becerra, who has oddly and repeatedly refused to acknowledge that partial-birth abortion is illegal, led HHS's charge to fund Big Abortion. In 2021, Planned Parenthood received more than $5.4 million in taxpayer funds from HHS, an amount that is sure to increase over the next three years.

In an effort to further fund Planned Parenthood, the Biden-Becerra HHS ignored democratic norms to rush through new Title X regulations. Title X is a federal program that provides grants for a range of family planning services, but per the statute, such services cannot include abortion.

The new regulations, however, remove the requirement of physical and financial separation between Title X projects and abortion services, require abortion counseling and referrals, and remove conscience protections for Title X providers. Planned Parenthood had dropped out of the Title X program under those regulations, forfeiting that funding stream, but under the new regulations the abortion giant is expected to receive significant Title X funding.

8. Comingling Insurance Payments for Abortion

Last summer, HHS rushed through new insurance regulations that, contrary to the text of the Affordable Care Act, no longer require separate insurance payments for abortion services, allowing those payments to be comingled with payments for other covered services. Besides violating the law, combined payments create a lack of transparency and accountability. Consumers with conscience objections to abortion will no longer be on notice that their insurance plan covers abortion or that they are subsidizing abortions, including for any adult children on their plan.

9. Rescinding Faith-Based Waivers

Prompting a congressional inquiry, the Biden-Becerra HHS gratuitously rescinded waivers previously issued to faith-based adoption and foster care agencies in Michigan, South Carolina, and Texas that allowed the agencies to qualify for HHS grants while operating in accordance with their deeply held religious beliefs. In the press release announcing the rescission, Becerra unironically stated: "At HHS, we treat any violation of civil rights or religious freedoms seriously."

Please. This action comes on the heels of a unanimous ruling by the Supreme Court affirming the constitutional right of foster-care agencies to act according to their religious beliefs on human sexuality in certifying foster parents.

"*For example, even if the rule substantially burdened religious practices, a religious exemption would not be required if that burden was the result of the government's advancement of a compelling interest by means that were least restrictive of religious exercise in particular contexts*."[38]

Here the Department claims that forcing provision of elective abortion is a compelling government interest, which raises serious concerns about why the Department has a compelling government interest in forcing elective abortion on vulnerable populations, including the forcing of elective abortion on communities of color. This raises serious concerns about the eugenic interests of the Department. We request the Department to answer in writing this question: **In what way is increasing the provision of elective abortion, especially in communities of color where the elective abortion rates are well above the rates of elective abortion in Caucasian communities, a compelling government interest?** After *Dobbs*, there is no constitutional right to choose an abortion and compelling federal government interest in abortion access This statement in the NPRM that elective abortion remains a compelling government interest implies an underlying commitment to population reduction in communities of color.

[38] 87 Fed. Reg. 47839

"*For example, this provision is consistent with OCR's civil rights clearance process required of providers seeking initial certification or undergoing a change of ownership to be certified as a Medicare Part A provider by CMS.*[39] *In order to obtain a civil rights clearance, would-be Medicare Part A providers and businesses must have nondiscrimination policies and procedures, including: policies and procedures to identify and communicate orally and in writing with LEP individuals; policies and procedures to ensure effective communication for individuals with disabilities, including, where necessary, the provision of appropriate auxiliary aids and services; and a description of how Medicare providers and applicants make their program accessible to persons with disabilities, among other things.*[4041] *This proposed provision would establish similar obligations. Under this proposed provision, covered entities may need to revise any pre-existing policies and procedures to ensure they, at minimum, include the proposed required content.*
The Department acknowledges that requiring covered entities to develop and implement Section 1557 Policies and Procedures for their health programs and activities would be a departure from previous rulemakings, , under which covered entities that implemented such policies and procedures did so voluntarily. However, the Department's enforcement and compliance assistance experience demonstrates that interventions such as implementing policies and procedures can result in covered entities being better positioned ***to prevent discriminatory conduct*** *and to better avoid the risk of an employee providing services in a discriminatory manner.*"[42] *[bold underline mine]*

In this section the Department acknowledges that bludgeoning health care professionals and health care entities into the provision of elective abortion or face the threat of sex discrimination charges has not been done before, but then justifies this Stalinistic police state enforcement by saying such action will "*prevent discriminatory conduct*".[43]

This is an unprecedented arbitrary and capricious use of agency discretion to force compliance with a political agenda which compels provision of elective abortion, a forced compliance which is specifically prohibited by Congress,the courts, and laws HHS is bound to follow and enforce.

"*Specifically, as noted above, we believe that such a proactive measure will more effectively increase covered entities' employees' knowledge of their responsibilities under Section 1557. The Department acknowledges that Section 1557 Policies and Procedures are not a panacea for eliminating discrimination in health care; however, we emphasize that our experience has indicated that*

[39] *See Civil Rights Clearance for Medicare Provider Applicants,* U.S. Dep't of Health & Human Servs., Office for Civil Rights, *https://www.hhs.gov/ civil-rights/for-providers/clearance-medicare- providers/index.html* (last updated Oct. 26, 2021).
[40] *See Technical Assistance for Medicare Providers and Applicants,* U.S. Dep't of Health & Human Servs., Office for Civil Rights, *https:// www.hhs.gov/civil-rights/for-providers/clearance- medicare-providers/technical-assistance/index.html* (last updated Oct. 27, 2021).
[41] FR 37160, 37204 (Jun. 19, 2020) (''To the extent that [the referenced statutes'] implementing regulations have . . . grievance procedures, they are sufficient for enforcement of Section 1557.'').
[42] 87 Fed. Reg. 47839
[43] 87 Fed. Reg. 47839 See bold in quotation highlighted

implementing policies and procedures that are the same or similar to the proposed Section 1557 Policies and Procedures helps prevent future instances of discriminatory conduct."[44]

It is clear that in totalitarian regimes, the threat by government to punish any action which does not match the political whims of the regime will decrease the number of people willing to act according to conscience. The Department can draw on the historical experience of countries such as Soviet Russia, Maoist China and others who force health care professionals to kill human beings or else be forced out of the health care profession. But those examples should never mirror our political system here in the United States. This kind of federal coercion has never been exercised before, as the Department readily admits in the NPRM. This coercion cannot be tolerated under the US Constitution, nor should it be tolerated in any type of rulemaking.

"*Proposed paragraph (a)(2) clarifies that discrimination on the basis of sex includes discrimination on the basis of sex stereotypes; sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; and gender identity".*[45]

Pregnancy and related conditions are euphemisms which attempt to hide the inclusion elective abortion. This definition would give the Department full power to punish the health professional or a health entity that protects preborn human beings and refuses to end the life of preborn patients for no medical reason.

The Department tries to justify the egregious inclusion of termination of pregnancy by stating: *The proposed inclusion of ''pregnancy or related conditions'' is consistent with the longstanding interpretation of sex discrimination under Title IX, including the Department's Title IX implementing regulation."*[46] However, the inclusion of termination of pregnancy under sex discrimination is clearly completely inconsistent with Title IX, **because Title IX has an abortion neutrality provision.** Indeed, nothing in Title IX requires provision or benefit of abortion and thus neither does Section 1557.. The Departments inclusion of pregnancy termination in their definition of sex discrimination in this NPRM is inconsistent with the explicit abortion neutrality provision of Title IX.

The Department then tries to justify the inclusion of elective abortion under sex discrimination by appealing to Title VII and the recent Bostock decision.

"Second, Title IX's ''on the basis of'' sex language is sufficiently similar to ''because of'' sex under Title VII as to be considered interchangeable."[47]

However, Bostock has nothing at all to do with health care, HHS, Section 1557 or the inclusion of elective abortion in definitions of sex discrimination. Indeed, Title VII itself (the employment

[44] 87 Fed. Reg. 47839
[45] 87 Fed. Reg. 47855
[46] 87 Fed. Reg. 47855
[47] 87 Fed. Reg. 47855

discrimination statue at issue in Bostock) contains an abortion exclusion from its sex discrimination definition (Title VII, Section 701(k)).

"Equal Program Access on the Basis of Sex (§92.206)

The Department proposes to include a section clarifying covered entities' obligation to ensure equal access to their health programs and activities without discrimination on the basis of sex, including pregnancy, sexual orientation, gender identity, and sex characteristics.[48] *This provision primarily relates to covered entities that are directly engaged in the provision of health care services, such as hospitals, physical and mental health care providers, and pharmacies*…."[49]

The inclusion of termination of pregnancy under the definition of sex discrimination opens all health professionals, including pharmacists and all health care entities to charges of sex discrimination for not participating in ending the lives of preborn human beings. This is not the will of the people as expressed by Congress, but rather is an open attempt by the Department to force compliance with the provision of elective abortion by all health care professionals and all health care entities and is incompatible with a democracy as well as incompatible with the practice of medicine which first does no harm to patients born or preborn.

"By contrast, a gynecological surgeon may be in violation of the rule if they accept a referral for a hysterectomy but later refuse to perform the surgery upon learning the patient is a transgender man. If OCR were to receive a complaint in a case such as this, it would evaluate whether the provider had a legitimate basis for concluding that the surgery would not be clinically appropriate for the patient. If the surgeon invokes such a justification, OCR would make a determination as to whether the reason was a pretext for discrimination. OCR would also consider the application of Federal conscience and religious freedom laws, where relevant.
Proposed paragraph (c) provides that nothing in this section requires the provision of any health service where the covered entity has a legitimate, nondiscriminatory reason for denying or limiting that service, including where the covered entity reasonably determines that such health service is not clinically appropriate for that particular individual. However, a provider's view that no gender transition or other gender-affirming care can ever be beneficial for such individuals (or its compliance with a state or local law that reflects a similar judgment) is not a sufficient basis for a judgment that a health service is not clinically appropriate."[50]

Although not the primary focus of the American Association of Pro-Life Obstetricians and Gynecologists, the wrongheaded rationale of the Department in this paragraph deserves comment. If a physician thinks that in their best medical judgement, a particular line of treatment is futile or even detrimental, then it is not the jurisdiction of the Department to demand that a particular political agenda be imposed in that doctor patient relationship. It is not the expertise of the Department to declare by fiat, and without any scientific justification, what is or is not the judgement of the medical professional

[48] *See* discussion *supra* section II.B. (The 2020 Rule's Preamble Does Not Reflect Recent Developments in Civil Rights Law).
[49] 87 Fed. Reg. 47861
[50] 87 Fed. Reg. 47863

in a doctor patient relationship. It is particularly egregious that this paragraph would attempt to force a gynecologist to remove a functioning organ for a political reason. This is an egregious overreach by the Department and must be removed. HHS should not use a nondiscrimination law to create a medical standard of care.

The Department is also considering whether §92.208 should include a provision to specifically address discrimination on the basis of pregnancy-related conditions.[51] Although neither the 2016 nor the 2020 Rules included a stand-alone provision prohibiting discrimination on the basis of pregnancy-related conditions, the 2016 Rule defined discrimination ''on the basis of sex'' to include, inter alia, discrimination on the basis of ''pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions.''[525][354] The 2020 Rule does not include a definition of ''on the basis of sex'' at all, and therefore does not specifically include in the Section 1557 regulation a prohibition on discrimination on the basis of a person's ''termination of pregnancy'' or other conditions related to pregnancy. The 2020 Rule does, however, prohibit discrimination on any of the ''grounds'' prohibited under Title IX,[523] and the Department's Title IX regulation, in turn, includes a provision expressly prohibiting discrimination on the basis of pregnancy-related conditions, including childbirth, false pregnancy, termination of pregnancy, and recovery therefrom.[524] Under this proposed rule, too, recipients would be required to comply with the specific prohibitions on discrimination found in the Department's Title IX regulations (including the regulation prohibiting discrimination on the basis of pregnancy-related conditions, including childbirth, false pregnancy, termination of pregnancy, and recovery therefrom).[55] In that respect it would not deviate from the 2016 or the 2020 Rule.

At the same time the Department promulgated the 2020 Rule, the Department amended its Title IX regulations to expressly include Title IX's statutory abortion neutrality provision,[5657] and included in the Department's Section 1557 regulation a provision stating that the Section 1557 regulations may not be applied insofar as they would ''depart from, or contradict,'' Title IX exemptions, rights, or protections.[527] This aspect of the 2020 Rule has been challenged in litigation.[528] This NPRM proposes repealing 45 CFR 92.6(b), the provision of the 2020 Rule challenged in those cases. The Department's view is that Section 1557 does not require the Department to incorporate the language of Title IX's abortion neutrality provision[529] into its Section 1557 regulation. This approach is consistent with the 2016 rule, which also did not incorporate Title IX's abortion neutrality provision. We acknowledge that the Franciscan Alliance court vacated the challenged provisions of the 2016 rule and reasoned that the Department was required to incorporate the language of Title IX's abortion neutrality provision; however, we disagree with that decision, which does not bind this new rulemaking.

The Department does note, however, that there are several other statutory and regulatory provisions related to the provision of abortions that may apply to an entity covered by Section 1557, and OCR will

---

[51] Such a provision would supplement proposed 92.101(a)(2), in which the Department proposes to define ''on the basis of sex'' to include pregnancy discrimination. *See* discussion *supra* §92.101(a)(2).

[52] Former 45 CFR 92.4. Although the *Franciscan Alliance* court vacated the inclusion of the term ''termination of pregnancy'' in the 2016 Rule's definition of discrimination on the basis of sex, that vacatur neither applies to this current rulemaking, nor to a possible new final provision prohibiting discrimination on the basis of pregnancy-related conditions.

[53] CFR 92.2(a), (b)(2).

[54] CFR 86.40(a).

[55] *See* proposed 45 CFR 92.101(b).

[56] *See* 85 FR 37243 (promulgating 45 CFR

[57] .18(b)).

apply such provisions consistent with the law. For example, the Weldon Amendment forbids funds appropriated to HHS, among other Departments, from being ''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.''[530] The Coats-Snowe Amendment forbids discriminating against an entity that refuses to undergo training in performance or referrals for abortions.[531] The Church Amendment forbids requiring any individual ''to perform or assist in the performance of any part of a health service program if his performance or assistance in the performance of such part of such program . . . would be contrary to his religious beliefs or moral convictions.''[532] It also provides that an entity's receipt of any grant, contract, loan, or loan guarantee under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Services and Facilities Construction Act ''does not authorize any court or any public official or other public authority to require . . . such entity to . . . make its facilities available for the performance of any sterilization procedure or abortion if the performance of such procedure or abortion in such facilities is prohibited by the entity on the basis of religious beliefs or moral convictions.''[533] The Church Amendment also prohibits discrimination against health care personnel related to their employment or staff privileges because they ''performed or assisted in the performance of a lawful sterilization procedure or abortion.''[534] The same nondiscrimination protections also apply to health care personnel who refuse to perform or assist in the performance of sterilization procedures or abortion.[535] In addition, some of HHS' programs and services are specifically governed by abortion restrictions in the underlying statutory authority or program authorization.[536] [58]

The discussion in this section gives lip service to the protections available to health care professionals and health care entities. The Department shows clearly that one of the express purposes of this NPRM is to force both health care professionals and faith-based institutions to perform elective abortions with no medical, conscience or religious exceptions. The religious exception being referred to in this section allows health care professionals and health care entities to not be forced to provide elective abortions. By refusing to include the abortion neutrality language of Title IX, the Department is transparently seeking to force faith based and religious institutions to participate in the elective killing of preborn human beings.

The Department is also fully well aware that the current statutory conscience protections in fact **depend on the Department itself to enforce**, as none of the current conscience protections have a private right of action. The existing laws are insufficient to protect anyone or any entity's conscience on the issue of elective abortion, as none of the statutory conscience protections allow for the person or entity to sue, but instead depend on HHS to sue on behalf of the person or entity to protect conscience rights, a position which HHS implies in this NPRM document that it will refuse to protect.

[58] 87 Fed. Reg. 47873

"The Department also notes in this regard that the Emergency Medical Treatment and Active Labor (EMTALA) provides rights to individuals when they seek examination or treatment and appear at an emergency department of a hospital that participates in Medicare.[537] If that person has an ''emergency medical condition,'' the hospital must provide available stabilizing treatment, including abortion, or an appropriate transfer to another hospital that has the capabilities to provide available stabilizing treatment, notwithstanding any directly conflicting state laws or mandate that might otherwise prohibit or prevent such treatment"[59]

It is nonsensical to read this statement from the Department and understand any interpretation of these words outside of a promotion of elective induced abortion. There is no state law that prohibits any emergency treatment. In fact, there is no state law that prohibits separation of the previable child from it's mother to save the life of the mother. What state laws prohibit is the killing of preborn human beings for no medical reason. Thus the Department is clearly using this guidance, as well as the EMTALA guidance as a way of forcing emergency department personnel and hospital systems to participate in elective abortion.

The Department conveniently forgot that EMTALA also requires treatment and stabilization of the unborn child. Applying EMTALA guidance to force health care providers and entities to participate in elective abortion is completely misconstruing the EMTALA statute. AAPLOG and others have sued to prevent the Department from ignoring the EMTALA imperative to act in the interests of the fetus, and it is most certainly clear that elective abortion- done for the purpose of producing a dead child- is not in the best interests of the child.

Included as Appendix B of this document is AAPLOG's position on elective abortion in the EMTALA guidance. Excerpts included here:

1. The Biden Administration's response to *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022), which ended the terrible regime of *Roe v. Wade*, is to attempt to use federal law to transform every emergency room in the country into a walk-in abortion clinic. President Biden is flagrantly disregarding the legislative and democratic process—and flouting the Supreme Court's ruling before the ink is dry—by having his appointed bureaucrats mandate that hospitals and emergency medicine physicians must perform abortions. But Defendants' Abortion Mandate forces hospitals and doctors to commit crimes and risk their licensure under Texas law, while doing nothing to advance the health and safety of women. The Emergency Medical Treatment and Labor Act (EMTALA) that Defendants cite as the basis for their Abortion Mandate does not authorize— and has never authorized—the federal government to compel healthcare providers to perform abortions. Instead, it expressly requires that

[59] 87 Fed. Reg. 47873

physicians protect the health and safety of both pregnant women and their unborn children. Defendants' Abortion Mandate is unlawful and must be set aside.

I. PARTIES

2. Plaintiff the State of Texas is a sovereign State of the United States.

3. Plaintiff the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG) is the largest organization of pro-life Ob/Gyns in the world and is headquartered in Michigan. AAPLOG includes Ob/Gyns and other physicians, with over 6,000 medical professionals nationwide, including over 300 members in Texas. AAPLOG members oppose elective abortion and are committed to the care and well-being of their patients including both pregnant women and their unborn children. AAPLOG sues on behalf of its members.
4. Plaintiff the Christian Medical and Dental Associations (CMDA) is a national nonprofit organization, headquartered in Tennessee, of Christian physicians, dentists, and allied health care professionals, with over 12,000 members nationwide. This includes 1,237 overall members in Texas, of whom 607 are practicing or retired physicians, and 35 are Ob/Gyns. CMDA is opposed to the practice of abortion as contrary to Scripture, respect for the sanctity of human life, and traditional, historical and Judeo-Christian medical ethics. CMDA sues on behalf of its members.
5. Defendant Xavier Becerra is Secretary of the United States Department of Health and

Human Services (HHS). He is sued in his official capacity.

6. Defendant HHS is a cabinet-level executive branch department of the United States.

7. The Centers for Medicaid and Medicare Services (CMS) is a division of HHS.

8. Defendant Karen L. Tritz is Director of the Survey & Operations Group of CMS. She is

sued in her official capacity.

9. David R. Wright is Director of the Quality, Safety and Oversight Group of CMS. He is sued in his official capacity.

II. JURISDICTION & VENUE

10. This Court has jurisdiction under 5 U.S.C. §§ 702 and 703 and 28 U.S.C. §§ 1331, 1346, and 1361, and *Larson v. Domestic & Foreign Com. Corp.*, 337 U.S. 682, 689–91 (1949).
11. The Court is authorized to award the requested declaratory and injunctive relief under 5 U.S.C. §§ 702, 705, and 706 and 28 U.S.C. §§ 1361, 2201, and 2202.
12. The Court is authorized to award costs and attorneys' fees under 42 U.S.C. 1988(b) and

28 U.S.C. § 2412.

13. Venue is proper within this District under 28 U.S.C. § 1391.

III. BACKGROUND

14. The Social Security Act, of which EMTALA is part, and its interaction with other federal healthcare laws are extensive and complex, but they have never required abortions. Defendants have instead weaponized the complexity of their authorizing statutes, while ignoring Congress' explicitly pro-life language, to issue a mandate that runs afoul of multiple federal statutes as described below. The interlocking federal statutes and requirements lead to one conclusion: the federal executive branch cannot achieve its unlawful policy outcomes by attempting to codify a federal right to abortion where none exists.

A. *Dobbs v. Jackson Women's Health Organization*

15. On June 24, 2022, the Supreme Court of the United States overturned *Roe v. Wade*, 410 U.S. 113 (1973), and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). *Dobbs*, 142 S. Ct. at 2242. The Supreme Court clarified that "the Constitution does not confer a right to abortion," "does not prohibit the citizens of each State from regulating or prohibiting abortion," and returned the issue of abortion to the States. *Id.* at 2279, 2284. "The Constitution does not prohibit the citizens of each State from regulating or prohibiting abortion." *Id.* at 2284.

B. The Biden Administration's Response to *Dobbs*

16. On the day the Supreme Court announced its decision in *Dobbs*, President Biden held a press conference and announced that "[t]he only way we can secure a woman's right to choose and the balance that existed is for Congress to restore the protections of *Roe v. Wade* as federal law."[60]

17. The next day, Secretary Becerra stated in an interview to NBC News that Americans "can no longer trust" the Supreme Court.[61] When asked what Secretary Becerra was doing "in response to the Court's decision,"[62] he responded, "we have no right to do mild. And so we're going to be aggressive and go all the way."[4]

18. On July 8, 2022, President Biden issued an Executive Order titled "Protecting Access to Reproductive Healthcare Services." Exec. Order No. 14,076, 87 Fed. Reg. 42053 (2022).[63] That

[60] *Remarks by President Biden on the Supreme Court Decision to Overturn Roe v. Wade*, The White House (June 24, 2022), https://www.whitehouse.gov/briefing-room/speechesremarks/2022/06/24/remarks-by-president-biden-on-the-supreme-court-decision-to-overturnroe-v-wade/ (last visited July 28, 2022).

[61] *HHS Secretary Becerra talks women's future with abortion following Roe v. Wade decision* (NBC NEWS broadcast June 25, 2022), https://www.nbcnews.com/video/women-s-future-withabortion-implementing-harm-reduction-with-addiction-142836293922, at 1:45 (last visited July 28, 2022).

[62] *Id.* at 2:19. [4] *Id.* at 2:59.

[63] Available at https://www.federalregister.gov/documents/2022/07/13/2022-15138/protectingaccess-to-reproductive-healthcare-services.

Order required Secretary Becerra to submit a report to the President "identifying steps to ensure that all patients—including pregnant women and those experiencing pregnancy loss, such as miscarriages and ectopic pregnancies—receive the full protections for emergency medical care afforded under the law, including by considering updates to current guidance on obligations specific to emergency conditions and stabilizing care under the Emergency Medical Treatment and Labor Act [EMTALA], 42 U.S.C. 1395dd." *Id.* at 42054.

19. That same day, Jen Klein, the Director of the White House Gender Policy Council, announced that President Biden "took immediate action under his executive authority to defend reproductive rights" when the *Dobbs* decision was issued, and that his July 8 order "builds on those actions."[64]

20. Four days later, President Biden announced HHS's new mandate purporting to override individual states' abortion laws under the authority of EMTALA.[65]

C. EMTALA

21. In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA). Congress enacted EMTALA "to prevent 'patient dumping,' which is the practice of refusing to treat patients who are unable to pay." *Battle ex rel. Battle v. Mem'l Hosp. at Gulfport*, 228 F.3d 544, 557 (5th Cir. 2000). With the enactment of EMTALA, every Medicare-participating hospital must provide medical screening and stabilizing treatment for emergency medical conditions regardless of a patient's ability to pay. 42 U.S.C. § 1395dd.

22. EMTALA specifically defines "stabilizing treatment" and "emergency medical conditions."

23. EMTALA defines "emergency medical condition" to include "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in–(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily function or part." 42 U.S.C. § 1395dd (e)(1)(A).

24. "To stabilize" means "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility." 42 U.S.C. § 1395dd(e)(3).

25. But the Social Security Act, of which EMTALA is part, contains an important limitation: "[n]othing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided . . . or to exercise any supervision or control over the administration or operation of any such institution, agency, or person [providing health services]." 42 U.S.C. § 1395.

---

[64] Press Briefing by Press Secretary Karine Jean-Pierre, THE WHITE HOUSE (July 8, 2022), https://www.whitehouse.gov/briefing-room/press-briefings/2022/07/08/press-briefing-bypress-secretary-karine-jean-pierre-4/, (last visited July 28, 2022).

[65] President Biden (@POTUS), TWITTER (July 12, 2022, 3:25 PM), https://twitter.com/potus/?lang=en.

26. EMTALA does not mandate, direct, approve, or even suggest the provision of any specific treatment. It says nothing requiring abortion.

27. Instead, EMTALA requires the stabilization of emergency medical conditions posing serious jeopardy to patients *including* the "unborn child," specifying the need to protect the "unborn child" four times. *Id.*

28. Federal appellate courts have confirmed that EMTALA confers no right to any specific treatment and does not operate as federal oversight on the practice of medicine. "The statutory language of the EMTALA clearly declines to impose on hospitals a national standard of care." *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995).

29. "Congress enacted the EMTALA not to improve the overall standard of medical care, but to ensure hospitals do not refuse essential emergency medical care because of a patient's inability to pay." *Id.* at 1258.

30. Accordingly, the relevant inquiry under EMTALA is "whether the challenged procedure was identical to that provided similarly situated patients, as opposed to whether the procedure was adequate as judged by the medical profession." *Id.*; *see also Marshall on Behalf of Marshall v. E. Carroll Par. Hosp. Serv. Dist.*, 134 F.3d 319, 323–24 (5th Cir. 1998) (holding that to show a violation of EMTALA, a plaintiff must "show that the Hospital treated her differently from other patients"). "A hospital's liability under EMTALA is not based on whether the physician . . . failed to adhere to the appropriate standard of care." *Battle*, 228 F.3d at 557; *see also Guzman v. Mem'l Hermann Hosp. Sys.*, 637 F. Supp. 2d 464, 487 (S.D. Tex. 2009) (Rosenthal, J.) ("EMTALA does not create a national standard of care and is not a medical malpractice statute.").

31. The standard of medical care is determined by the state and the community in which the treatment took place. *E.g.*, *Hannah v. United States*, 523 F.3d 597 (5th Cir. 2008); *Quijano v. United States*, 325 F.3d 564 (5th Cir. 2003); *see also Birchfield v. Texarkana Mem'l Hosp.*, 747 S.W.2d 361 (Tex. 1987).

32. State laws regulating abortion, and state laws protecting conscientious objections to abortion, form an essential part of the state's regulation of the practice of medicine and of the standard of medical care relating to abortion.

33. No federal statute confers a right to abortion. EMTALA is no different. It does not guarantee access to abortion. On the contrary, EMTALA contemplates that one of the qualifying requirements for treatment of an emergency medical condition is one that threatens the life of the unborn child. *See* 42 U.S.C. § 1395dd(e)(1)(A)(i). It is obvious that abortion does not stabilize the unborn child from serious jeopardy faced by an emergency medical condition, nor does it preserve the life or health of an unborn child.

34. EMTALA provides for civil enforcement actions against both hospitals and physicians. 42 U.S.C. § 1395dd(d). Hospitals and physicians are each subject to a civil penalty of up to $119,942 for each violation. *Id.* at § 1395dd(d)(1)(A)–(B); 45 C.F.R. § 102.3.

D. The Abortion Mandate

35. On July 11, 2022, the Centers for Medicare and Medicaid Services issued agency guidance to all State Survey Agency Directors titled "Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss" (EMTALA Guidance).[66]

Additionally, Secretary Becerra issued a letter to providers[67] describing the guidance (together, the "Abortion Mandate"). The EMTALA Guidance purports to simply remind hospitals of their existing obligations under federal law.[68] But it does not: it includes several new requirements related to the provision of abortions that do not exist under federal law.

36. The Abortion Mandate requires that a provider perform an abortion if "abortion is the stabilizing treatment necessary to resolve [an emergency medical condition]."[69] This condition has never been a part of EMTALA.

37. At the time of the Abortion Mandate and the Executive Order that preceded it, there was no evidence that violations of EMTALA were occurring which precluded women from receiving emergency care for miscarriages and ectopic pregnancies, and Defendants cited no such evidence.

38. Indeed, Texas law already expressly provides that treatment of a miscarriage and removal of an ectopic pregnancy do not constitute abortion. Tex. Health & Safety Code §245.002(1)(B)-(C). Even until very recently Planned Parenthood distinguished between abortion and treatment of ectopic pregnancies—but that distinction was removed from Planned Parenthood's website shortly after the EMTALA Abortion Mandate was released.[70]

39. The Abortion Mandate nowhere acknowledges the duty under EMTALA to stabilize the unborn child from serious jeopardy posed by an emergency medical condition.

40. The EMTALA Guidance also claims that "[w]hen a state law prohibits abortion and does not include an exception for the life of the pregnant person—or draws the exception more narrowly than EMTALA's emergency medical condition definition—***that state law is preempted***."[71] 41. This has also never been a part of EMTALA. To the contrary, EMTALA "do[es] not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of [EMTALA]." 42 U.S.C. § 1395dd(f).

---

[66] Exh. 1 *Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss*, CENTERS FOR MEDICARE & MEDICAID SERVICES (July 11, 2022), https://www.cms.gov/files/document/qso-20-15-hospital-cah-emtala-revised.pdf (last visited July 28, 2022).

[67] Exh. 2 Letter to Health Care Providers, SECRETARY OF HEALTH AND HUMAN SERVICES, https://www.hhs.gov/sites/default/files/emergency-medical-care-letter-to-health-careproviders.pdf (last visited July 28, 2022).

[68] Exh. 1 at 2.

[69] Exh. 1 at 1.

[70] Chloe Folmar, "Planned Parenthood website removes distinction between etopic pregnancy and abortion," *The Hill* (July 26, 2022), https://thehill.com/homenews/state-watch/3570880planned-parenthood-website-removes-distinction-between-ectopic-pregnancy-and-abortion/ (last visited July 28, 2022).

[71] Exh. 1 at 1–2 (emphasis in original).

42. The health conditions in which the EMTALA Guidance purports to require abortions are far broader than the life of the mother exception found in Texas laws concerning abortion or the federal Hyde Amendment, but instead include undefined "health" conditions of a pregnant woman (which, under *Roe*, included emotional and social health), situations such as "incomplete medical abortions," and undefined and open-ended situations that do not presently threaten the life of the mother but are "likely . . . to become emergent."[72]

43. EMTALA does not mandate access to abortion or codify a right to an abortion as "stabilizing treatment" for an "emergency medical condition." The Abortion Mandate cites no other federal law that would authorize or require an abortion. No federal statute, including EMTALA, supersedes or preempts the States' power to regulate or prohibit abortion.

44. The EMTALA Guidance further specifies that "an emergency medical condition that has not been stabilized" can include "a patient with an incomplete medical abortion," and that the sorts of abortion that EMTALA can require include "methotrexate therapy" or "dilation and curettage."[73]

45. Thus the EMTALA Guidance attempts to force hospitals and physicians to complete medical abortions (otherwise known as chemical abortions) that began elsewhere, even illegally.

46. The Abortion Mandate, by threatening to punish hospitals and physicians in failing their duty to stabilize patients, inherently threatens to second-guess the medical judgment or moral or religious beliefs of a hospital or physician who concludes that an abortion is not an appropriate response in a particular situation, and to subject the hospital or physician to penalties after the fact for allegedly failing in their stabilization duty based on the new abortion standard of care set forth in the EMTALA Guidance.

47. The risk of after-the-fact liability is not hypothetical. It is how EMTALA is enforced by HHS. For instance, a physician or hospital could decline to complete a chemical abortion, proposing instead to reverse the abortion and stabilize both the mother and the unborn child as EMTALA requires. Should the woman refuse that treatment and subsequently complete the abortion elsewhere, however, the refusing physician or hospital may be accused of "dumping" the patient, triggering potential liability by HHS CMS and HHS's Office of the Inspector General.

E. Federal Laws and Appropriation Statutes Prevent Federal Abortion Mandates

48. None of these mandates existed in federal law before this Executive Order.

49. Instead, the Hyde Amendment prohibits federal funds from being used to pay for abortions except in cases of rape, incest, or a threat to the life of the mother. Consolidated Appropriations Act, 2022, Pub. L. No. 117-103, Div. H., Tit. V, §§ 506–07.

50. The Weldon Amendment prohibits federal agencies from discriminating against any institutional or individual health care entity "on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions." *Id.*

[72] Exh. 1 at 1.

[73] 15 *Id.* at 4, 6.

51. The Coats-Snowe Amendment prohibits "[t]he Federal Government" from discriminating against any health care entity on the basis that it refuses to perform induced abortions or to provide referrals for such abortions. 42 U.S.C. § 238n.

52. The Church Amendments prohibits recipients of funds from HHS from discriminating against personnel because they refuse to perform or assist an abortion based on their religious or moral beliefs, and prohibits any requirement that an individual in an HHS funded health or research program perform or assist in procedures contrary to his religious or moral beliefs. 42 U.S.C. § 300a-7(c) & (d).

53. And an agency cannot accomplish through administrative action something that which it is prohibited from doing by statute. *See, e.g., BST Holdings, LLC v. Occupational Safety & Health Admin.*, 17 F.4th 604, 611–12 (5th Cir. 2021).

F. Texas Abortion Statutes

1. Human Life Protection Act

54. The Human Life Protection Act states that "[a] person may not knowingly perform, induce, or attempt an abortion." Act of May 25, 2021, 87th Leg., R.S., ch. 800, 2021 Tex. Sess. Law Serv. 1887 (H.B. 1280) (to be codified at Tex. Health & Safety Code Ch. 170A). That prohibition does not apply if the woman on whom the abortion is performed "has a life-threatening physical condition" arising from a pregnancy that places her "at risk of death or poses a serious risk of substantial impairment of a major bodily function unless the abortion is performed." H.B. 1280 at § 2 (to be codified at Tex. Health & Safety Code § 170A.002(b)(2)). The potential criminal penalty for violating this law is anywhere from two years to life in prison and a civil penalty not less than $100,000. *Id.* (to be codified at Tex. Health & Safety Code §§170A.004–.005); Tex. Penal Code §§ 12.32–.33.

55. The Human Life Protection Act is effective on the thirtieth-day after the issuance of a United States Supreme Court judgment in a decision overruling *Roe v. Wade*. H.B. 1280 at § 3(1). No further action by the Texas Legislature or any state official is required—it is certain that these provisions will become effective.

56. Texas law protects the right of physicians to decline to directly or indirectly perform or participate in an abortion procedure. Tex. Occ. Code § 103.001.

2. Pre-*Roe* Criminal Statutes

57. In addition to the Human Life Protection Act, Texas has several statues predating *Roe* that address the subject of abortion. *See* Tex. Rev. Civ. Stat. arts. 4512.1–.4, .6. (2010) (former Tex. Penal Code arts. 1191–1194, 1196 (1925)). Under those statutes, any person who causes an abortion is guilty of an offense and shall be confined in a penitentiary. *Id.* at 4512.1. Moreover, an individual may not act as an accomplice to abortion or an attempted abortion. *Id.* at 4512.2–.3. However, it is not on offense if the abortion is performed under "medical advice for the purpose of saving the life of the mother." *Id.* at 4512.6.

58. These laws have never been repealed, and this criminal prohibition on abortion is currently the law in Texas. As the Texas Supreme Court has explained, "[w]hen a court declares a law unconstitutional, the law remains in place unless and until the body that enacted it repeals it, even though the government may no longer constitutionally enforce it." *Pidgeon v. Turner*, 538 S.W.3d 73, 88 n.21 (Tex. 2017). And the Legislature never repealed Articles 4512.1–.4 and .6. Instead, they were merely moved from the Texas Penal Code to the Texas Revised Civil Statutes. *See* Act of May 25, 1973, 63rd Leg., R.S., ch. 399, § 5(a), 1973 Tex. Gen. Laws 883, 995 ("provid[ing] for the transfer of articles of the Penal Code of Texas, 1925, which are not repealed by this Act to the civil statutes or other appropriate places within the framework of Texas statute law, without reenactment and without altering the meaning or effect of the unrepealed articles.").

G. The Effects of the Abortion Mandate in Texas

59. Texas is injured because the Abortion Mandate purports to preempt its laws. This violates

Texas's "sovereign interest in the power to create and enforce a legal code." *Texas v. United States*, 809 F.3d 134, 153 (5th Cir. 2015) (quotation omitted). The sovereign right to enforce its criminal laws is the epitome of Texas's police power.

60. Furthermore, the State of Texas operates hospitals that participate in Medicare and Medicaid. The EMTALA Guidance explicitly threatens the CMS provider agreements for any healthcare providers that refuse to abide by the Abortion Mandate.[74] These hospitals are now threatened with having to choose between violating state law under threat of criminal penalty or jeopardizing their ability to participate in Medicare and State health care programs, *e.g.*, Medicaid.

61. 61. By requiring Medicare-participating hospitals, including hospitals operated by the State of Texas, to provide abortions when the life of the mother is *not* in danger, the Abortion Mandate directly infringes on Texas's sovereign and quasi-sovereign authority.

62. In 2020, Medicare hospital expenditures exceeded $1.2 billion, amounting to 36% of total national health expenditures.[75] For most hospitals, more than half of patient revenue is attributable to Medicaid and Medicare.[76] The intended consequence of the Abortion Mandate is that numerous physicians and

[74] Exh. 1 at 5 ("HHS OIG may also exclude physicians from participation in Medicare and State health care programs. CMS may also penalize a hospital by terminating its provider agreement."); *see also* 1 Tex. Admin. Code § 354.1077 (requiring a hospital to "be enrolled and participating in the Medicare Program as a hospital" to participate as a hospital in Texas Medicaid).

[75] *NHE Fact Sheet*, CENTERS FOR MEDICARE & MEDICAID SERVICES, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-andReports/NationalHealthExpendData/NHE-Fact-Sheet (last visited July 14, 2022).

[76] *Medicare and Medicaid*, TEXAS HOSPITAL ASSOCIATION, https://www.tha.org/issues/medicareand-medicaid/ (last visited July 14, 2022).

hospitals in Texas will be threatened with extensive civil penalties and loss of livelihood as a result of following State law.

63. Under Texas law, if a physician commits a violation of State law "connected with the physician's practice of medicine," Tex. Occ. Code § 164.053(a)(1), the physician's license may be revoked or suspended. *Id.* at § 164.001; § 164.052(a)(5). Accordingly, if Texas physicians violate State law by providing abortions when the life of the mother is not in danger, they risk losing their medical licenses.

64. Texas has a quasi-sovereign and *parens patriae* interest in protecting the rights of its citizens and vindicating them in court. Thus, Texas may sue to challenge unlawful actions that "affect [its] public at large." *In re Debs*, 158 U.S. 51, 584 (1895).

H. The Effects of the Abortion Mandate on AAPLOG and CMDA

65. AAPLOG and CMDA have members in Texas and around the country who care for pregnant women in emergency situations at hospitals subject to EMTALA.

66. AAPLOG's and CMDA's Texas members are protected by law in their conscientious objection to participating in abortions under Tex. Occ. Code § 103.001, and under the Church, Coats-Snowe, and Weldon Amendments listed above.

67. The Abortion Mandate purports to establish a standard of care that requires abortions in various circumstances faced by AAPLOG's and CMDA's members in Texas and other states.

68. The Abortion Mandate purports to require abortions by AAPLOG's and CMDA's members in various circumstances not posing a risk to the life of the mother.

69. For example, the Abortion Mandate requires performing essentially an elective abortion where women present to an emergency room, having previously initiated chemical abortions, but where the unborn child is still living and may still be preserved.

70. Intrauterine pregnancy itself is not an acute condition requiring any immediate intervention under EMTALA, and thus does not fit the criteria for EMTALA intervention. Intrauterine pregnancy is a normal bodily function.

71. Because these broader conditions include elective abortions where the woman's life is not at stake but which may constitute "stabilizing care" under the Abortion Mandate, the effect of the Abortion Mandate is to force the performance of elective abortions by both physicians and health care entities, to protect abortion providers who violate state law, and to require pro-life hospitals to allow those doctors to perform abortions in their facilities.

72. In cases where the unborn child's life can still be preserved, the Abortion Mandate purports to require AAPLOG's and CMDA's members to perform, assist in, or refer for abortions in violation of Texas law, the pro-life laws of other states, and EMTALA itself which requires stabilization of the unborn child.

73. AAPLOG and its members object to being forced to end the life of a human being in the womb for no medical reason. The objections are both ethical and medical and stem from the purpose

of medicine itself, which is to heal and not to electively kill human beings regardless of their location.[77]

74. AAPLOG has issued several position statements and medical practice bulletins on situations threatening the life of the mother and the need to not conflate legitimate treatments provided in such circumstances with abortion provided in broader circumstances.[78]

75. CMDA and its members similarly affirm the historical prohibition against abortion in the Christian Church and in application of the Hippocratic Oath. Their objections are Biblical, biological, social, medical, and ethical.[79]

76. The Abortion Mandate's requirement that AAPLOG's members perform abortions in elective circumstances would force AAPLOG's members to violate their sincerely held religious or moral beliefs or medical judgment.

77. The Abortion Mandate's requirement that CMDA's members perform abortions in circumstances not justified by CMDA's members' religious beliefs about protecting the life of the mother and her unborn child would force CMDA's members to violate their sincerely held religious or moral beliefs or medical judgment.

78. The Abortion Mandate forces AAPLOG's and CMDA's Texas members to choose between following state laws and their own consciences prohibiting certain abortions and violating the Abortion Mandate, or following the Abortion Mandate and violating state law and their consciences.

79. The Abortion Mandate threatens crippling punishments against AAPLOG's and CMDA's members for failing to comply, including fines of $119,942 per violation and loss of qualification for federal programs such as Medicaid and Medicare.

80. These threats of punishment under EMTALA chill the exercise of religion of CMDA's members and AAPLOG's religious members. Further these threats of punishment serve to coerce both AAPLOG and CMDA members to act in violation of their best medical judgement exercised on behalf of both of their patients, the pregnant mother and the human being in her womb.

81. As examples, the following members of AAPLOG or CMDA illustrate the harms imposed by the Abortion Mandate.

82. Dr. Sean Hutzler is an emergency medicine physician in Corpus Christi, Texas, and is affiliated with multiple hospitals in the area.

83. Dr. Hutzler is a member of AAPLOG and is also a member of the Catholic Church.

[77] *See Position Statements*, AAPLOG, https://aaplog.org/resources/position-statements/(last visited July 28, 2022).

[78] *See, e.g., What is AAPLOG's Position on "Abortion to Save the Life of the Mother?"?*, AAPLOG, https://aaplog.org/what-is-aaplogs-position-on-abortion-to-save-the-life-of-the-mother/ (last visited July 28, 2022); *Premature Delivery is Not Induced Abortion*, AAPLOG, https://aaplog.org/premature-delivery-is-not-induced-abortion/ (last visited July 28, 2022); and *Practice Bulletin 10*, AAPLOG, https://aaplog.org/wp-content/uploads/2020/12/FINALAAPLOG-PB-10-Defining-the-End-of-Pregnancy.pdf (last visited July 28, 2022).

[79] *See Abortion*, CHRISTIAN MED. & DENTAL ASS'NS, https://cmda.org/abortion/ (last visited July 28, 2022).

84. Dr. Hutzler shares the views of AAPLOG and of the Catholic Church concerning abortion and the medical treatment that is appropriate for women and their unborn children.

85. As an emergency medicine physician, Dr. Hutzler regularly treats pregnant women who come to the emergency room in situations subject to EMTALA. He has treated many women with complications arising during pregnancy, including ectopic pregnancy.

86. Dr. Hutzler provides the best care possible to women and their unborn children in such circumstances, and has complied with EMTALA, state law, and his medical, ethical, and religious beliefs.

87. Dr. Hutzler seeks to practice medicine consistent with his medical and ethical views, his religious beliefs, and state law, but is concerned that the Abortion Mandate could be enforced to require involvement in abortions inconsistent with his views, his beliefs, and state law.

88. Dr. Michael T. Valley is an Ob/Gyn with board certified specialties in obstetrics and gynecology and urogynecology.

89. Dr. Valley practices in Minnesota and covers the emergency department at hospitals in Waconie and Chaska, Minnesota.

90. Dr. Valley is a member of AAPLOG and is also a member of the Catholic Church.

91. Dr. Valley shares the views of AAPLOG and of the Catholic Church concerning abortion and the medical treatment that is appropriate for women and their unborn children.

92. In covering the emergency department of two hospitals as an Ob/Gyn, Dr. Valley regularly treats pregnant women who come to the emergency room in situations subject to EMTALA.

93. Dr. Valley provides the best care possible to women and their unborn children in such circumstances, and has complied with EMTALA, state law, and his medical, ethical, and religious beliefs.

94. Dr. Valley seeks to practice medicine consistent with his medical, ethical, and religious views, but is concerned that the Abortion Mandate could be enforced to require involvement in abortions inconsistent with those views.

95. Dr. Steven A. Foley is an Ob/Gyn in Anderson, Indiana, and he also practices in Colorado Springs, Colorado.

96. Dr. Foley is a member of CMDA and shares its views concerning abortion and the medical treatment that is appropriate for women and their unborn children.

97. Dr. Foley is associated with several hospitals, works as a hospitalist, and also covers the emergency department for hospitals.

98. Dr. Foley regularly treats pregnant women who come to the emergency room in situations subject to EMTALA.

99. Dr. Foley provides the best care possible to women and their unborn children in such circumstances, and has complied with EMTALA, state law, and his medical, ethical, and religious beliefs.

100. Dr. Foley seeks to practice medicine consistent with his medical, ethical, and religious views, but is concerned that the Abortion Mandate could be enforced to require involvement in abortions inconsistent with those views.

101. Without injunctive relief, the members of AAPLOG and CMDA will be forced to violate their best medical judgement as well as their conscience and religious liberty rights and compliance with state abortion bans, in order to avoid massive financial federal penalties and maintain Medicaid and Medicare eligibility—and therefore preserve their livelihoods as physicians and careers serving patients.

102. AAPLOG and CMDA have no remedies available at law.

103. For each of the claims below, Plaintiffs reallege and incorporate the allegations set forth in paragraphs 1 through this paragraph of this first amended complaint.

IV. CLAIMS FOR RELIEF

COUNT 1 Defendants Acted *Ultra Vires* in Promulgating the Guidance

104. Defendants lack statutory authority to promulgate regulations altering or amending the requirements of EMTALA.

105. Defendants lack statutory authority to promulgate rules or regulations mandating that

Medicare-participating hospitals and their physicians provide access to—and perform—abortions. 106. Moreover, under the Social Security Act, only the Secretary of HHS has authority to promulgate rules or regulations. 42 U.S.C. § 1395hh(a). The EMTALA Guidance was not issued by the Secretary of HHS but by Defendants Wright and Tritz, who lack authority to promulgate rules or regulations. *See id.*

107. Further, whether Defendants possess the political and constitutional authority they claim is a major question of "deep economic and political significance" that Courts will not assume that Congress has assigned to the Executive Branch. *See King v. Burwell*, 576 U.S. 473, 486 (2015); *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 160 (2000). "We presume that Congress intends to make major policy decisions itself, not leave those decisions to agencies." *West Virginia v. Env't Prot. Agency*, 142 S. Ct. 2587, 2609 (2022) (internal quotations omitted).

108. As the President has acknowledged,[80] and as the Supreme Court has held,[81] the question of abortion is now properly up to the people's elected representatives—not unelected bureaucrats. Using EMTALA to impose an abortion mandate is "unprecedented" in the statute's 36 year history. *Cf. West Virginia*, 142 S. Ct. at 2611.

109. Defendants acted *ultra vires* and exceeded the scope of their authority.

COUNT 2 The Abortion Mandate Exceeds Statutory Authority and Is Not in Accordance with Law 5 U.S.C. § 706

[80] *Remarks by President Biden on Protecting Access to Reproductive Health Care Services*, THE WHITE HOUSE (July 8, 2022), https://www.whitehouse.gov/briefing-room/speeches-remarks/2022/07/08/remarks-by-president-biden-on-protecting-access-to-reproductive-healthcare-services/ (last visited July 14, 2022).

[81] *Dobbs*, 142 S Ct. at 2284.

110. The Abortion Mandate is being "applied . . . in a way that indicates it is binding." *Texas v. EEOC*, 933 F.3d 433, 441 (5th Cir. 2019). Therefore, it is an agency action subject to judicial review under the APA.

111. Under the APA, a court must "hold unlawful and set aside agency action" that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" or "in excess of statutory . . . authority, or limitations, or short of statutory right." *See* 5 U.S.C. § 706(2)(A), (C).

112. EMTALA does not authorize the Abortion Mandate. It nowhere allows Defendants to require abortions, nor to establish a nationwide standard of care requiring abortions. Instead, in EMTALA itself Congress denied Defendants authority to mandate abortions by requiring that the

"unborn child" be stabilized. And EMTALA explicitly precludes the Abortion Mandate's attempt to preempt state law since EMTALA contains no abortion mandate, much less one that "directly conflicts" with state law. 42 U.S.C. § 1395dd(f).

113. The Abortion Mandate is promulgated "[i]n light of the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*" and attempts so codify a "legal duty" to provide an abortion.[82] But Defendants lack statutory authority to exercise "any supervision or control over the practice of medicine or the manner in which medical services are provided." 42 U.S.C. § 1395. Defendants also lack statutory authority to codify a federal right to abortion.

114. The Abortion Mandate also conflicts with federal law's ban on the federal government discriminating against hospitals and healthcare providers that do not provide, assist, or refer patients for abortions. Consolidated Appropriations Act, 2022, Pub. L. No. 117-103, Div. H., Tit. V, §§ 506–07; 42 U.S.C. § 238n; 42 U.S.C. § 300a-7.

115. In addition, the Abortion Mandate conflicts with the Hyde Amendment, which prohibits federal dollars from being used for abortions except when the pregnancy is the result of rape or incest or the woman's life is in danger. Consolidated Appropriations Act, 2022, Pub. L. No. 117103, Div. H., Tit. V, §§ 506–07. By conditioning the receipt of Medicare funds on providing abortions under the terms of the Abortion Mandate, Defendants are requiring the use of federal dollars to coerce healthcare providers to supply abortions outside the allowable scope under the Hyde Amendment. Consolidated Appropriations Act, 2022, Pub. L. No. 117-103, Div. H., Tit. V, §§ 506–07.

116. The Department of Justice's appropriation act prevents it from using any funds to "require any person to perform, or facilitate in any way the performance of, any abortion." Consolidated Appropriations Act of 2022, Pub. L. 117-103, 136 Stat. 131, Div. B., Tit. II, § 203. The DOJ's defense of the Abortion Mandate would necessarily mean that it would be expending federal dollars to facilitate the performance of abortions.

117. Defendants did not act in accordance with the law and exceeded their statutory authority when they issued the Abortion Mandate.

COUNT 3 Failure to Conduct Notice and Comment 5 U.S.C. § 553 42 U.S.C. § 1395hh

[82] Exhibit 1 at 1, 5.

118. Defendants must comply with notice-and-comment requirements before promulgating a rule. 5 U.S.C. § 553; 42 U.S.C. § 1395hh(b).
119. Subject to certain statutory exceptions not implicated here, a "[g]eneral notice of proposed rulemaking shall be published in the Federal Register." 5 U.S.C. § 553(b). "After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments." 5 U.S.C. § 553(c). "The required publications or service of a substantive rule shall be made not less than 30 days before its effective date [with applicable exceptions]." 5 U.S.C. § 553(d).
120. The Social Security Act stipulates that "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing the scope of benefits" or "payment for services . . . shall take effect unless it is promulgated by the Secretary," and subject to limited exceptions not applicable here, subject to notice and comment. 42 U.S.C.
§ 1395hh(a)(2), (b).
121. Notwithstanding its unconvincing disclaimer,[83] the Abortion Mandate substantively changes the conditions for payment for services by requiring Medicare-participating hospitals and physicians to perform abortions.
122. The Abortion Mandate has binding effect, uses mandatory language, imposes rights, obligations, and duties, and leaves the agency and its decision-makers without discretion to interpret or apply EMTALA in a contrary way.
123. Accordingly, Defendants were required to provide an opportunity for public notice and comment.
124. Even if Defendants were authorized by statute to promulgate the Abortion Mandate, which they are not, the Court would still have to set it aside for failure to comply with the notice-andcomment requirements. "The reviewing court shall hold unlawful and set aside agency action, findings, and conclusions found to be without observance of procedure required by law." 5 U.S.C.
§ 706(2)(D).

COUNT 4 Arbitrary and Capricious Agency Action 5 U.S.C. § 706(2)(A)

125. "Normally, an agency rule would be arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

126. "[A]gency action" is "the whole or a part of an agency rule, order, license, sanction, relief, or the equivalent or denial thereof, or failure to act." 5 U.S.C. § 551(13). An agency "rule" is defined as "the whole or a part of an agency statement or general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of an agency." *Id.* at § 551(4).

[83] Exh. 1 at 1.

127. An agency action is arbitrary or capricious if it fails to "articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made." *Motor Vehicle Mfrs. Ass'n of U.S., Inc.*, 463 U.S. at 43. Under the APA, a court must "hold unlawful and set aside agency action" that is "arbitrary and capricious." 5 U.S.C. § 706(2)(A).

128. Defendants did not engage in reasoned decision-making, but instead acted arbitrarily and capriciously, in issuing the Abortion Mandate. The Guidance contains no explanation or reasoning at all. Mere executive fiat falls well short of the requirement of a "satisfactory explanation."

129. The Abortion Mandate does not acknowledge the agency's change in position from never having previously required abortions under EMTALA; it offers no reasoned explanation of how EMTALA can require abortions when EMTALA requires stabilizing the "unborn child"; it offers no explanation of the interaction between its mandate and religious freedom and conscience laws; it discusses no reliance interests by regulated entities, especially pro-life physicians and hospitals, on never having previously been subject to an abortion mandate under EMTALA; and it discusses no alternative approaches.

130. The Guidance is arbitrary and capricious and must be set aside.

COUNT 5

Ultra vires

Unconstitutional Exercise of Spending Power

131. "[I]f Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously," so "States [can] exercise their choice knowingly." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). The executive branch cannot impose conditions on spending that the Constitution would prohibit it from imposing directly because that authority belongs to Congress. *See id.* at 17. Only Congress can condition the receipt of federal funds.

132. EMTALA does not condition—let alone unambiguously condition—the receipt of Medicare funds on providing abortions. Texas did not—and could not—have knowingly chosen to accept Medicare funds on the condition that its abortion laws be preempted because such a preemption does not exist and would be prohibited.

133. The Guidance is an unconstitutional condition on the State's receipt of federal funds. 134. The Court must set aside the Abortion Mandate because it is an unconstitutional exercise of Spending Power. 5 U.S.C. § 706(A), (c).

COUNT 6

Ultra vires

Unconstitutional Delegation of Legislative Power

135. Under Article I, § 1 of the Constitution, because "[a]ll legislative powers herein granted shall be vested in a Congress of the United States," only Congress may engage in lawmaking. "Congress is not permitted to abdicate or to transfer to others the essential legislative functions with which it is thus vested." *A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 529– 30 (1935).

136. This nondelegation doctrine bars Congress from transferring its legislative power to another branch of Government.

137. Congress may delegate power to executive agencies only if that delegation includes an intelligible principle to which the delegee "is directed to conform." *J.W. Hampton, Jr., & Co. v. United States*, 276 U.S. 394, 409 (1928).

138. This is necessary to preserve the Constitutionally mandated separation of powers.

139. If the Social Security Act is so broad it allows Defendants to implement a national right to abortion—irrespective of State laws—Congress did not articulate an intelligible principle authorizing such agency action.

COUNT 7

Ultra Vires

Violation of the Tenth Amendment

140. The structure of the U.S. Constitution and the text of the Tenth Amendment protect federalism.

141. The powers not delegated by the Constitution to the federal government are reserved to the States.

142. "[T]he Constitution does not confer a right to abortion," "does not prohibit the citizens of each State from regulating or prohibiting abortion," and "return[ed] that authority to the people and their elected representatives." *Dobbs*, 142 S. Ct. at 2279, 2284. Thus, the authority to regulate abortion in Texas rests with the State of Texas.

143. "[T]he regulation of health and safety matters is primarily, and historically, a matter of local concern." *Hillsbrough Cnty., Fla. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 715 (1985). "Historic police powers of the States" are not superseded by federal law unless that is "the clear and manifest purpose of Congress." *Id.*; *City of Columbus v. Ours Garage & Wrecker Serv. Inc.*, 536 U.S. 424, 432 (2002).

144. For all these reasons, the Abortion Mandate an unconstitutional exercise of authority and must be held unlawful and set aside.

COUNT 8

Religious Liberty

Violation of RFRA and the Free Exercise Clause of the First Amendment

145. Under the First Amendment to the U.S. Constitution, "Congress shall make no law

respecting an establishment of religion, or prohibiting the free exercise thereof . . . ." U.S. Const. amend. I. And under the Fifth Amendment to the U.S. Constitution, "No person shall be * * * deprived of life, liberty, or property, without due process of law." U.S. Const. amend. V.

146. The Religious Freedom Restoration Act (RFRA) prohibits the federal government from substantially burdening a person's exercise of religion, unless the government demonstrates that the burden is the least restrictive means of furthering a compelling government interest. 42 U.S.C.

§ 2000bb-1(a).

147. CMDA asserts the rights of its members under the Free Exercise Clause and RFRA. 148. CMDA's members exercise their religious beliefs in practicing medicine by caring for patients generally, and in caring for patients in situations subject to EMTALA.

149. CMDA's members exercise their religious beliefs in treating pregnant women and their unborn children with respect and dignity, and in opposing involvement in the direct and intentional killing of unborn children in abortion.

150. The Abortion Mandate burdens the religious exercise of CMDA's sincerely held religious beliefs, and does so in a substantial way.

151. The Abortion Mandate is not supported by a compelling government interest, and is not the least restrictive means of advancing such an interest.

152. The Abortion Mandate exerts significant pressure on CMDA's members to violate their beliefs in order to continue providing healthcare in federally funded health programs and activities or else face exclusion from those programs, loss of funding, loss of livelihood, and fines, investigations, and other punishments from Defendants.

153. Upon information and belief, the Abortion Mandate specifically and primarily burdens religious conduct, favors some religious beliefs over others, and is motivated by animus and hostility towards the religious beliefs of pro-life physicians and hospitals.

154. The Abortion Mandate allows prosecutorial discretion by Defendants so as to not be neutral or generally applicable under the Free Exercise Clause.

155. The Abortion Mandate, and Defendants' enforcement thereof, violates the rights of

CMDA's members under the Free Exercise Clause of the First Amendment and RFRA.

V. DECLARATORY JUDGMENT

156. The federal Declaratory Judgment Act authorizes federal courts to declare the rights of litigants. 28 U.S.C. § 2201. The issuance of a declaratory judgment can serve as the basis for an injunction to give effect to the declaratory judgment. *Steffel v. Thompson*, 415 U.S. 452, 461 n. 11 (1974).

157. For the reasons described above, Plaintiffs are entitled to a declaration that the Defendants are violating the law and the Abortion Mandate is unlawful, unconstitutional, and unenforceable.

VI. PRAYER FOR RELIEF

For these reasons, Plaintiffs respectfully request that the Court:

i. Hold unlawful and set aside the Abortion Mandate.

ii. Declare the Defendants' actions unlawful.

iii. Issue preliminary and permanent injunctions prohibiting Defendants from enforcing the Abortion Mandate.

iv. Award Plaintiffs' costs and reasonable attorneys' fees.

v. Award such other relief as the Court deems equitable and just.

"*The Department believes it could be beneficial to include a provision specifically prohibiting discrimination on the basis of pregnancy-related conditions as a form of sex-based discrimination. We seek comment on whether and how the Department should do so. We also seek comment on what impact, if any, the Supreme Court decision in Dobbs v. Jackson Women's Health Organization*[538] *has on the implementation of Section 1557 and these regulations. In light of the Dobbs decision and E.O. 14076,*[539] *the Department also seeks comments on other approaches to ensure nondiscriminatory access to care under this provision."*[84]

In an overwhelming display of deceit, the Department refers obliquely to effect of the Dobbs decision on prohibiting discrimination on the basis of pregnancy related conditions. Clearly Dobbs refers to the provision of elective abortion and the ability of the states to regulate elective abortion provision. Thus the Department here abandons any plausible deniability that one of the primary intents of this NPRM 1557 guidance is to further the provision of elective abortion, despite Congressional and court prohibitions about forcing health care professionals and health care entities to participate in the killing of preborn human beings.

"*Though Congress did not require the Department to incorporate the language of Title IX abortion-neutrality provision in its Section 1557 regulations, we seek comment on this approach and on other possible readings of the Title IX abortion-neutrality provision, as well as whether the Department should align its Title IX regulation regarding the abortion neutrality provision of Title IX with the 2000 ''Common Rule'' version of that regulatory provision that more than 20 agencies have long adopted*."[85]

If the Department is truly seeking comment on Abortion Neutrality Language, HHS should incorporate Title IX's abortion neutrality provision. The Department should infer from the explicit Congressional inclusion of abortion neutrality language in Title IX that Congress has not in the past and does not now intend for Departments to ride roughshod over the conscience rights of medical professionals and health care entities and try to force by this NPRM or any other guidance medical professionals or health care entities to participate in the elective killing of preborn human beings.

" *Proposed paragraph (a) provides that a recipient may raise with the Department its belief that the application of a specific provision or provisions of this regulation as applied to it would violate Federal conscience or religious freedom laws. Such laws include but are not limited to the Coats-*

[84] 87 Fed. Reg. 47873
[85] 87 Fed. Reg. 47873

Snowe Amendment, Church Amendments, RFRA, section 1553 of the ACA, section 1303 of the ACA, and the Weldon Amendment. Recipients are also reminded that they can file complaints regarding Federal conscience laws with OCR, as provided in 45 CFR part 88.

Proposed paragraph (b) provides that once OCR receives a notification pursuant to proposed paragraph (a), OCR shall promptly consider those views in responding to any complaints." [86]

If the Department seriously intended to protect the conscience rights of physicians and health care entities who do not want to participate in the elective killing of preborn human beings, the Department would have included the abortion neutrality language from Title IX.

The Department's unwillingness to include abortion neutrality language, combined with the fact that the Department knows full well that any enforcement of conscience violations are under the control of the Department makes the inclusion of this statement above transparently hypocritical. The quote above is a remarkably disingenuous statement requiring clarification from the Department.

What enforcement of conscience rights can a medical professional or health care entity expect from the same Department who is by publishing this NPRM violating the conscience rights of the medical professional and health care entity?

"*OCR maintains an important civil rights interest in the proper application of Federal conscience and religious freedom protections. In enforcing Section 1557, OCR is thus committed to complying with RFRA and all other legal requirements. The Department believes that the proposed approach in this section will assist the Department in fulfilling that commitment by providing the opportunity for recipients to raise concerns with the Department, such that the Department can determine whether an exemption or modification of the application of certain provisions is appropriate under the corresponding Federal conscience or religious freedom law. As noted above, the Department also maintains a strong interest in taking a case-by-case approach to such determinations, which will allow it to account for any harm an exemption could have on third parties*[595] *and, in the context of RFRA, to consider whether the application of any substantial burden on a person's exercise of religion is in furtherance of a compelling interest and is the least restrictive means of advancing that compelling interest.*[596] [87]

AAPLOG requests the Department to clarify in writing **what compelling government interest is involved in advancing elective abortion especially in communities of color**?

Clearly the Department in this NPRM is committed to expanding elective abortion, even over the rights of states to regulate the practice of medicine within their borders. Clearly the Department in this NPRM is determined to ride roughshod over the conscience rights of medical professionals and health care entities without regard to their right to not participate in the intentional destruction of preborn

[86] 87 Fed. Reg. 47879
[87] 87 Fed. Reg. 47879

human beings. **How can anyone take seriously the OCR interest in maintaining civil rights, when OCR is under the Department who is clearly intending to violate those rights? HHS's promise to respect conscience and religious freedom rights falls flat.**

The Department seeks comment on this approach, including whether such a provision should include additional procedural information, the potential burdens of such a provision on recipients and potential third parties, and additional factors that the Department should take into account when considering the relationship between Federal conscience and religious freedom laws and Section 1557's civil rights protections. We also seek comment on what alternatives, if any, the Department should consider.[88]

AAPLOG urges the Department to take into consideration the lives of the human beings in the womb who are being destroyed for no medical reason in the Department's blind pursuit of expansion of elective abortion.

AAPLOG also requests the Department to specifically respond in writing to our stated questions and concerns in this document.

Respectfully submitted,

Donna J. Harrison, M.D.

Donna J. Harrison M.D.
C.E.O.
American Association of Pro-Life Obstetricians and Gynecologists

[88] 87 Fed. Reg. 47879