19-4254

20-31, 20-32, 20-41 (con.)

UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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

Plaintiffs-Appellees,

(Caption continued on inside cover)

On Appeal from the United States District Court
for the Southern District of New York, No. 19 Civ. 4676
Before the Honorable Paul A. Engelmayer

BRIEF FOR 158 CURRENT MEMBERS OF CONGRESS AS *AMICI CURIAE* IN SUPPORT OF APPELLEES

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

Consolidated-Plaintiffs-Appellees,

v.

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

Defendants-Appellants,

DR. REGINA FROST, CHRISTIAN MEDICAL AND DENTAL ASSOCIATION,

Intervenors-Defendants-Appellants,

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

Consolidated-Defendants-Appellants.

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INTEREST OF *AMICI CURIAE*[1]

Amici are 25 Senators and 133 Representatives duly elected to serve in the 116th Congress of the United States. *Amici* are committed to maintaining and expanding access to medical care, and as representatives of the public, they have a strong interest in ensuring that Congress's statutes and other legislation, including its health care laws, are properly interpreted and enforced.

Amici and their predecessors drafted, debated, and enacted the statutes that the Department of Health and Human Services' 2019 Final Rule purports to interpret. *Amici* offer their perspective, as Members of Congress, on the meaning of the key provisions at issue in this case.

A full listing of *amici* appears in the Appendix.

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[1] Pursuant to Federal Rule of Appellate Procedure 29(a)(4)(E), *amici* affirm that no party or counsel for a party authored this brief in whole or in part and that no person other than *amici*, their members, or their counsel has made any monetary contributions intended to fund the preparation or submission of this brief. Counsel for the parties have consented to the filing of this brief.

INTRODUCTION

The United States Department of Health and Human Services (HHS) improperly sought to transform Congress's statutory scheme with its Rule, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority." Congress has consistently sought to protect and expand access to medical care in the United States, including by passing the Affordable Care Act in 2010, and in other statutes and legislation enacted over the last fifty years. HHS's Rule is one in a series of more recent attempts to turn back this progress and limit access to care, especially abortion care. In this brief, *amici curiae* explain why the Rule is inconsistent with Congress's intent in enacting the statutes at issue in this case, as well as with other statutes protecting access to medical care.

The three principal statutes at issue in this litigation, the Church Amendment, the Coats-Snowe Amendment, and the Weldon Amendment, *i.e.*, the "refusal statutes," prohibit "discrimination" against health care providers who refuse, in certain circumstances, to perform or assist in the performance of or refer a patient for certain procedures to which they have a moral or religious objection. The

refusal statutes are limited: all three statutes prohibit such "discrimination" with the understanding that the prohibition will not impair the right to or availability of the objected-to procedures.

The Rule unaccountably alters the settled understanding and meaning of the refusal statutes in ways that Congress did not intend and that would be harmful to patients. It would permit individuals to refuse to provide services and impede access to medical care even when they are not performing or present during the performance of procedures to which they object. It would prevent employers from inquiring whether physicians or nurses object to performing the services for which they are being hired. It would even allow health care professionals to deny and block emergency medical care.

As a result, patients seeking reproductive health care will lose health care under the Rule: objectors could deny emergency contraception to rape survivors, deny information and pregnancy counseling to those in need, or refuse care to those suffering from an ectopic pregnancy or miscarriage. Nor can patients assume, under the Rule, that those who object to providing care will provide any information to help them or even identify their condition, because the

Rule allows objectors to refuse to provide any information if the objector thinks the information would foreseeably lead to the provision of objected-to services.

The Rule would fall hardest upon our most underserved communities who already struggle with access to health care. For instance, the Rule's expansive and vague definitions threaten to embolden a wide range of objectors to deny or block reproductive health care or other care to LGBTQ individuals based on their sexual orientation or gender identity. In rural communities, a single pharmacist could block access to medication entirely. Individuals with disabilities who depend on providers for their care and lack the ability to find another one may find themselves without objected-to services.

In short, the effect of the Rule is to embolden objectors to erect barriers to medical care, thereby decreasing the availability of medical care, especially abortion and sterilization services. Because the Rule is harmful and contrary to the statutes that Congress enacted, the district court properly vacated the Rule. This Court should affirm.

ARGUMENT

I. Congress, Not HHS, Is Responsible for Balancing Competing Public Policy Concerns

All legislative powers that our Constitution grants are vested exclusively in Congress. U.S. Const. Art. I, § 1. It is the prerogative of Congress to make policy judgments and create laws that account for competing political, ethical, and moral considerations. "Congress's prerogative to balance opposing interests and its institutional competence to do so provide one of the principal reasons for deference to its policy determinations." *Salazar v. Buono*, 559 U.S. 700, 717 (2010).

Congress considered the competing interests at issue here and recognized the importance of preserving access to medical care, both in the refusal statutes and in other statutes. In promulgating the Rule, HHS impermissibly sought to override Congress's policymaking decisions and prioritize the Administration's policy objectives over those established by Congress. In doing so, HHS substantively transformed the refusal statutes in ways never intended by their drafters and created conflicts with other key statutes. This "transformative expansion," made without "clear congressional authorization," cannot stand. *Utility Air Regulatory Group v. EPA*, 573 U.S. 302, 324 (2014).

II. The Rule Impermissibly Alters the Scope of the Refusal Statutes

An agency may not transform the meaning of statutes. Yet that is what HHS attempted to do in promulgating the Rule.

A. Congress Limited the Scope of the Refusal Statutes

As noted, Congress has enacted three principal federal funding statutes at issue in this litigation—the Church Amendment, the Coats-Snowe Amendment, and the Weldon Amendment. These refusal statutes are limited in scope and effect, as their text and legislative history demonstrate.

1. The Church Amendment

Congress passed the Church Amendment in 1973, "in the wake of [*Roe v. Wade*, 410 U.S. 113 (1973)]." *Cenzon-DeCarlo v. Mount Sinai Hosp.*, 626 F.3d 695, 696 (2d Cir. 2010). The primary purpose of the Church Amendment was to clarify that the receipt of specified federal funds by individuals or entities did not authorize courts or other public officials to compel those recipients to perform abortions or sterilizations. *See* 42 U.S.C. § 300a-7(b).

In *Chrisman v. Sisters of St. Joseph of Peace*, for example, the plaintiff argued that because a private hospital received certain federal funding, it had acted under color of state law when it denied a requested sterilization procedure. 506 F.2d 308 (9th Cir. 1974). The Church Amendment foreclosed that argument. As the Ninth Circuit explained, "Congress sought to retain its neutrality in the debate over the morality of voluntary sterilizations by preventing the reception of federal health program funds from being used as a basis for compelling a hospital to perform such surgery against the dictates of its religious or moral beliefs." *Id.* at 311.

The Church Amendment also prohibits employment discrimination based on an employee's refusal *or willingness* to perform certain procedures. The statute provides that recipients of federal assistance may not discriminate in the "employment, promotion, or termination of employment of any physician or other health care personnel" or in the "extension of staff or other privileges to any physician or other health care personnel" because the employee "performed or assisted in the performance of a lawful sterilization procedure or abortion" or "refused to perform or assist in the

performance of such a procedure or abortion" on religious or moral grounds. 42 U.S.C. § 300a-7(c). Thus, in *Watkins v. Mercy Medical Center*, the district court held that a hospital "had violated 42 U.S.C. § 300a-7 by removing [a physician] from staff because of his belief that sterilizations and abortions *should be performed*." 520 F.2d 894, 896 (9th Cir. 1975) (emphasis added).

The purpose of the Church Amendment was narrow and limited. Under the statute, courts may not *compel* individuals to perform abortions or sterilizations over their religious or moral objection, and employers may not discriminate against individuals for performing or refusing to perform abortions or sterilizations. Senator Church himself repeatedly made clear, however, that the statute would *not* affect the ability of patients to receive such procedures or health care providers to perform them. He explained that "[t]his amendment would not in any way affect sterilizations or abortions in publicly owned hospitals," and that there would be "no great difficulty" for women to obtain an abortion. 119 Cong. Rec. 9600, 9601 (1973); *see also id.* at 9596 (statement of Senator Stevenson: "No individuals will be denied an abortion or sterilization....").

To effectuate its intent that the Church Amendment would not affect the availability of abortion or sterilization, Congress provided that the statute would apply only to individuals who "*perform or assist in the performance*" of abortion or sterilization procedures. 42 U.S.C. § 300a-7(b)-(d) (emphasis added). A "physician" performs a medical procedure, usually with the assistance of "healthcare personnel" such as nurses (42 U.S.C. § 300a-7(c)) who are present during the procedure. The statute thus applies to those who carry out a procedure, as distinguished from those who provide care or services before or afterwards and have only an attenuated relationship to services. By limiting the category of individuals who could claim "discrimination" to those who actually perform or assist in the performance of abortion or sterilization, the statute minimizes disruption of medical care and leaves willing physicians and personnel free to carry out those procedures.

The legislative history confirms this construction. During debate, one senator expressed concern that an abortion or sterilization procedure might "not be performed because there might be a nurse or an attendant somewhere in the hospital who objected to it," which

"could veto the rights of a physician and the rights of patients" to have such procedures. 119 Cong. Rec. 9597 (1973). Senator Church replied "that such is not my intention"; rather, "[t]he amendment is meant to give protection to the physicians, to the nurses, to the hospitals themselves, if they are religious affiliated institutions .... There is no intention here to permit a frivolous objection from someone unconnected with the procedure." *Id.*

Consistent with common sense, the Church Amendment does not apply to the provision of emergency health care, even when individuals may have a religious or moral objection to such care. Senator Church confirmed: "[I]n an emergency situation—life or death type—no hospital, religious or not, would deny such services." 119 Cong. Rec. 9601 (1973). The Church Amendment plainly does not permit a physician to refuse to provide life-saving medical care under the Amendment.

2. The Coats-Snowe Amendment

Congress passed the Coats-Snowe Amendment in 1996. The Amendment responded to concerns that medical accreditation organizations or state licensing boards would require OB/GYN

residency programs to offer abortion-related training. (SA 8-9) Senator Coats's stated intent was to maintain the status quo that had existed before the Accreditation Council for Graduate Medical Education promulgated a new standard requiring experience with "induced abortion" as part of a residency education, except in the case of religious objection. (SA 9 (quotation marks omitted))

The statute provides that government entities may not discriminate against any "health care entity" that refuses to "undergo training in the performance of induced abortions, to require or provide such training, to perform such abortions, or to provide referrals for such training or such abortions." 42 U.S.C. § 238n(a)(1). The "term 'health care entity' includes an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions." *Id.* § 238n(c)(2).

Congress did not intend that the Coats-Snowe Amendment would be construed to impair or limit the availability of medical care, including abortion. Quite the opposite—both sponsors of the Amendment promised that the legislation would *maintain* women's access to abortion care. Senator Coats stated that the Amendment was

"simply [to] address the question of training for induced abortions" and accreditation procedures. 142 Cong. Rec. 4926, 5158 (1996). As Senator Snowe explained: "This amendment would not only make sure that women have access to quality health care with the strictest of standards when it comes to quality and safety but it also will ensure that they have access to physicians who specialize in women's health care." *Id.* at 5164. Senator Coats added, "[w]e do not want to prevent those who voluntarily elect to perform abortions from doing so," and stressed that physicians would still receive sufficient medical training to be able to perform abortions. *Id.* at 5160, 5165.

As with the Church Amendment, a premise underlying the Coats-Snowe Amendment was that it would *not* alter the availability of abortion services. As Senator Coats stated, the Amendment would not preclude physicians from having "mastered the [abortion] procedure to protect the health of the mother if necessary" and physicians would "have the expertise necessary, as learned in those training procedures, should the occasion occur and an emergency occur to perform that abortion." 142 Cong. Rec. 5165-66 (1996).

3. The Weldon Amendment

A third statute that the Rule purportedly interprets is the Weldon Amendment, an appropriations rider first enacted in 2004. The Amendment provides that certain appropriated funds may not "be made available" to a federal or state agency or government if it "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." Pub. L. No. 115-245, Div. B., § 507(d)(1), 132 Stat. 2981, 3118 (2018). The Amendment defines "health care entity" as including "an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan." *Id.* § 507(d)(2).

By its terms, the Weldon Amendment does not regulate the activity of willing health care entities that *do* provide, pay for, provide coverage of, or refer for abortions. (SA 11) Thus, the Weldon Amendment continued to assume the existence of a large number of unaffected health care entities, such that neither the right to nor the availability of abortion would be impaired. As Representative Weldon

stated, "My amendment in no way infringes on a woman's ability to seek and receive elective abortions." 151 Cong. Rec. H177 (daily ed. Jan. 25, 2005) (statement of Rep. Weldon); *see also* SA 11 ("this provision will not affect access to abortion" (quoting statement of Representative Weldon)).

As with the Church Amendment, the Weldon Amendment does not apply to or affect emergency medical care. Representative Weldon repeatedly insisted that the Amendment would *not* apply in emergency situations. He stated that "[f]ederal law requires that an abortion be provided to a woman in a life-threatening situation" and rejected the idea "that the … amendment would somehow interfere with the State's desire to see abortion services offered as an emergency medical service." 151 Cong. Rec. H177; *see also id.* ("Hyde-Weldon ensures that in situations where a mother's life is in danger a health care provider must act to protect the mother's life.").

B. The Rule's Definitions Transform the Meaning and Effect of the Refusal Statutes

The Rule's definitions disregard statutory limits and expand the scope of the refusal statutes far beyond what Congress intended. In

particular, four key regulatory definitions impermissibly broaden the refusal statutes to impede the right to and availability of medical care and related information, in contravention of Congressional intent. Those definitions are: (1) “assist in the performance”; (2) “discriminate”; (3) “refer”; and (4) “health care entity.”

The definitions expand the categories of individuals and entities who may *claim* “discrimination” under the Rule in a complaint to HHS or as part of an investigation and also expand the types of conduct that may *constitute* “discrimination” against objecting individuals and entities. Thus, taken together, these definitions could result in a vast array of businesses and employees exercising veto power over essential health care.

1. “Assist in the Performance”

The Church Amendment provides that a recipient of federal assistance may not compel an individual or entity “to perform or *assist in the performance* of any sterilization procedure or abortion….” 42 U.S.C. § 300a-7(b) (emphasis added). The Rule defines “assist in the performance” as “to take an action that has a specific, reasonable, and articulable connection to furthering a procedure … undertaken by or

with another person or entity." 45 C.F.R. § 88.2. The Rule goes on to provide that "assist in the performance" "may include counseling, referral, training, or otherwise making arrangements for the procedure or a part of a health service program or research activity, depending on whether aid is provided by such actions." *Id.* This definition conflicts with the statute, which cannot be construed so broadly.

It is difficult to overstate the breadth of the Rule's definition of "assist in the performance." By applying to *any* individual who takes *any* action—so long as that action has a "specific, reasonable, and articulable connection to furthering a procedure" (itself a vague and inscrutable standard)—the Rule does exactly what Senator Church promised his Amendment would *not* do. Senator Church insisted that the Amendment would not affect access to abortion care. But the Rule would alter and impede access to and availability of abortion care because it purports to empower anyone to refuse care in any capacity at any time, including before or after a procedure.

The Rule would permit, for instance, a receptionist to refuse to schedule an abortion, or an ambulance driver to refuse to drive a woman to the hospital upon learning that she will need to receive an

abortion. *See* 84 Fed. Reg. 23188 (HHS clarifying that "assist in the performance" could apply to ambulance drivers). It would permit a janitor or nurse to refuse to clean a room in which procedures may be performed. It would permit radiologists, sonographers, and technicians to refuse to perform ultrasounds or take x-rays in advance of a procedure. It could even permit physicians or nurses to refuse to provide care long after a procedure had taken place, so long as the care aided in her recovery from and thereby furthered the procedure.

In short, the Rule invites every person within several degrees of separation of a procedure, or virtually every actor within our health care system, to impede care when a patient seeks an abortion or other objected-to procedure. This is not what Congress intended.

2. "Discriminate"

All three of the refusal statutes use the term "discriminate" or "discrimination." The Rule defines "discriminate" or "discrimination" to include an extensive list of actions. 45 C.F.R. § 88.2. And in subparagraphs added after HHS issued its notice of proposed rulemaking, the Rule adds substantive prohibitions and procedural

provisions that alter the ordinary and accepted understanding of the term "discriminate" or "discrimination."

For one, the Rule provides that an entity has not "engaged in discrimination" if the entity offers and a physician or other person or entity "*voluntarily accepts* an effective accommodation …." *Id.* (subparagraph (4) under definition of "discriminate" (emphasis added)). Thus, the definition would enable HHS to find that a State or entity discriminated against an objector, even when the State or entity offers the objector an accommodation, if the objector rejects the accommodation. The provision thus extends the meaning of "discriminate" to foreclose any arrangement that an objecting employee or entity does not accept. Congress did not intend for the term "discriminate" in the refusal statutes to have this meaning, especially given that it would conflict with an existing statutory scheme for accommodating religious beliefs and practices in the employment context, Title VII of the Civil Rights Act. *See infra*, at 22-23.

The Rule also provides that an employer may not even ask its employees whether they object to performing, counseling, referring for, or assisting in the performance of procedures unless "there is a

reasonable likelihood" that the employer would ask the employee to engage in such conduct. Moreover, an employer may not make such an inquiry until *after* hiring or contracting with an individual or entity, and then no more than "once per calendar year," unless a "persuasive justification" exists. 45 C.F.R. § 88.2 (subparagraph (5)). To define "discriminate" so as to prevent an employer from asking whether an applicant will perform central functions of the job for which he or she is being hired again extends the meaning of that term well beyond what the refusal statutes provide.

3. "Refer"

The Rule's definition of "refer" (or "referral") applies to the Coats-Snowe Amendment and Weldon Amendment, both of which prohibit discrimination against covered entities that refuse to "refer for abortions." Pub. L. No. 115-245, Div. B., § 507(d)(1); *see* 42 U.S.C. § 238n(a)(1). And because the Rule defines "assist in the performance" to include "referral" for a procedure, the definition of "refer" also purports to apply to and alter the scope of the Church Amendment as well. The Rule defines "refer" broadly to include the provision of information, including mere physical or website addresses, "where the

purpose or reasonably foreseeable outcome of provision of the information" is to "assist a person" in obtaining a health care service, program, activity, or procedure. 45 C.F.R. § 88.2.

The problem with the Rule in this respect is that in normal usage a "referral" is not the provision of any information, in any form, that has a reasonable chance of leading to an outcome. Rather, a "referral" is "[t]he act or an instance of sending or directing to another for information, service, consideration, or decision." *Referral*, Black's Law Dictionary (11th ed. 2019); *see also* 42 U.S.C. § 1395nn(h)(5); *United States v. Patel*, 778 F.3d 607, 612-13 (7th Cir. 2015).

The extraordinarily broad definition of "refer" in the Rule means that a narrow statutory provision for providers who object to giving a referral, as that term is ordinarily understood, would be converted into a broad authorization for objectors to withhold virtually any information they see fit to withhold on the ground that it would foreseeably assist a person in obtaining medical procedures. Thus, the definition of "refer" is contrary to the statutes and intent of Congress, which has never defined the term so broadly, and would hamper patients' ability to get information they need for their care.

4. "Health Care Entity"

The Rule defines "health care entity" for purposes of the Coats-Snowe Amendment and Weldon Amendment, respectively, adding numerous entities to the statutory definition of "health care entity" in each Amendment. The Rule expands the statutory definition of "health care entity" in the Coats-Snowe Amendment to include, among many other things, a pharmacist, a pharmacy, a medical laboratory, and an entity engaging in biomedical or behavioral research. 45 C.F.R. § 88.2. Similarly, the Rule expands the definition of "health care entity" in the Weldon Amendment to include all the entities listed in the Rule's definition for the Coats-Snowe Amendment, plus "a plan sponsor or third-party administrator." 45 C.F.R. § 88.2.

Because the definition of "health care entity" goes beyond what the statutes provided to encompass new categories of business such as pharmacies, laboratories, and plan sponsors and administrators, it would enable a range of new entities and their employees to refuse to "provide, pay for, provide coverage of, or refer for abortions." Pub. L. No. 115-245, Div. B., § 507(d)(1); *see also* 42 U.S.C. § 238n(a)(1). And because the Rule's definition of "refer" is broad and incorporated into

the definition of "assist in the performance," the Rule could lead to objections by customer service representatives, data entry clerks, and others distant from the procedure itself, all of whom could endeavor to frustrate a patient's right to obtain an abortion from willing doctors. This expansion of the refusal statutes to new entities and individual employees is likewise inconsistent with Congress's intent.

III. The Rule Is Contrary to Other Statutes

In addition to contradicting the intent of the refusal statutes themselves, the Rule is contrary to other laws that address related subject matter: Title VII of the Civil Rights Act and the Emergency Medical Treatment and Active Labor Act.

A. Title VII of the Civil Rights Act

Congress has already established a framework for ensuring that health care employers may provide services while respecting the religious beliefs and practices of health care employees. Title VII of the Civil Rights Act of 1964, as amended ("Title VII"), prohibits religious discrimination in employment by requiring employers to provide reasonable accommodation of employees' sincerely-held religious beliefs

when requested, unless doing so would impose an *undue hardship* on the employer in conducting business operations. 42 U.S.C. § 2000e(j); *Cosme v. Henderson*, 287 F.3d 152, 158 (2d Cir. 2002). Enacted one year before the Church Amendment (Pub. L. No. 92-261 § 2(7), 86 Stat. 103), Title VII's reasonable accommodation framework has for decades defined the duties of health care entities when addressing the religious objections of their employees.

Title VII's longstanding framework has engendered significant reliance interests in the health care field. For instance, the American Hospital Association commented during the rulemaking that "[h]ospitals have existing policies, procedures, and best practices" and "decades of experience with how to meet their responsibility to provide reasonable accommodations." (JA 1568) Likewise, the former chairperson of the Equal Employment Opportunity Commission explained in comments that Title VII is the "legal framework under which complaints of employment discrimination based on religion have been judged for over 40 years." (JA 2683) The Rule disrupts Title VII's framework and settled reliance interests in several ways.

First, the Rule defines "discrimination" in a manner that discards the "undue hardship" component of the Title VII framework. 84 Fed. Reg. 23191 ("The Department's approach will differ from Title VII, however, by not incorporating the additional concept of an 'undue hardship' exception for reasonable accommodations under Title VII."). The "undue hardship" feature protects health care employers from liability if they decline to provide an accommodation that would impose an undue hardship on the conduct of their business, *i.e.*, providing medical care. Without the undue hardship defense, the consequences for health care employers who are unable to accommodate a religious objection would be severe. Thus, as the district court correctly recognized, "HHS's decision not to recognize an undue hardship defense would shift, relative to the present framework set by Title VII, leverage from health care employers to employees who object to covered procedures …." (SA 33)

Patients would also suffer under HHS's Rule, relative to the Title VII framework, because the Rule enables objectors to foreclose access to abortion procedures and other care. For example, a remote women's health clinic could be subject to liability under the Rule's definition of

"discrimination" for declining to hire a doctor who refuses to perform, or a receptionist who refuses to schedule, a tubal ligation. Similarly, a rural pharmacy could be forced to allow its sole pharmacist to refuse to fill prescriptions or provide information about medication to manage a miscarriage, even if doing so would render the pharmacy unable to provide effective services to the local community. Removal of the "undue hardship" defense would tie the hands of health care employers, prioritizing employee accommodations over patient access to health care.

Second, the Rule violates Title VII by failing to protect an employer who offers an objecting employee a "reasonable accommodation." Under Title VII, an employer sued for religious discrimination is protected from liability if it shows that it offered its employee a reasonable accommodation. But the Rule's definition of "discrimination" ignores Title VII's "reasonable accommodation" feature. Rather, the Rule again tips the scale in favor of the objecting employee, leaving the health care employer vulnerable to losing funding unless the employer offers and the employee "*voluntarily accepts* an *effective* accommodation." 45 C.F.R. § 88.2(4) (emphasis added).

Thus, the Rule, unlike Title VII's reasonable accommodation framework, leaves health care employers in the untenable position of hiring or retaining employees who refuse to fulfill the central functions of their jobs. For example, a hospital could be forced to employ a nurse in its obstetrics and gynecology unit who refuses to perform miscarriage management or treat pregnancy complications, even if the hospital proposed—but the nurse refused—a transfer to a different department that does not perform objected-to procedures. Worse yet, the same hospital could be subject to the loss of all HHS-administered funding under the Rule, despite its good-faith effort to propose a reasonable accommodation to its employee.

Congress did not intend to replace Title VII when it enacted the refusal statutes. As applied to health care, the Title VII framework accommodates the sincerely-held religious beliefs of employees while also protecting access to health care without unnecessary and potentially life-threatening denials or delays. The Rule threatens to dismantle that framework by shifting leverage to those who refuse to provide care at the expense of patients and health care employers. Congress intended no such result.

B. The Emergency Medical Treatment and Active Labor Act

The Rule's expansive definitions also impede patients' access to emergency health services in direct violation of the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd, a statute Congress enacted in 1986. Under EMTALA, any hospital with an emergency department that receives Medicare funds must provide appropriate medical screening to patients to determine whether an emergency medical condition exists and stabilize the condition or, if medically warranted, transfer the patient to another facility. 42 U.S.C. § 1395dd(a)-(b)(1).

EMTALA's protection for emergency care is ironclad. A health care provider cannot, under any circumstances, refuse care during medical emergencies. Even the sponsors of the refusal statutes made clear that the statutes would not interfere with a patient's right to emergency care. *See supra,* at 9, 11, 13. The Affordable Care Act reinforced the same point. *See* 42 U.S.C. § 18023(d) ("[No provision] shall be construed to relieve any healthcare provider from providing emergency services as required by State or Federal law, including … 'EMTALA.'").

Disturbingly, the Rule prioritizes the objections of providers who turn away patients in emergency-care situations over the patients whose lives they endanger because it makes no exception for providers confronted with emergency medical situations. Thus, if a physician or nurse refused to provide emergency services, a hospital might have to choose between violating EMTALA and risking an HHS finding of "discrimination" under the Rule. This possibility forces hospitals into an unsustainable position. As the American College of Emergency Physicians explained in a comment submitted during rulemaking, to avoid liability under the Rule and EMTALA simultaneously, an emergency department would need to "anticipate every possible basis for a religious or moral objection, survey its employees to ascertain on which basis they might object, and staff accordingly." (JA 1921) Congress did not intend to impose this burden on hospitals and hardworking emergency room professionals. Nor did it intend to prioritize religious or moral objections over emergency medical care for patients.

CONCLUSION

This Court should affirm the judgment of the district court.

Dated: August 3, 2020

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that this document complies with the type-volume limit of Federal Rule of Appellate Procedure 32(a)(7)(B)(i), along with Local Appellate Rule 29.1(c) and 32.1(a)(4)(A), because, excluding the parts of the document exempted by Rule 32(f), this document contains 5,137 words as counted by the word-processing software used to create the brief.

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/s/ Brian A. Sutherland
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APPENDIX

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