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To: Doug Wilson, CEO
Catholic Benefits Association
From: L. Martin Nussbaum
Re: HHS 2022 Proposed Rule Related to Abortion and Gender-Affirming Care
Date: November 3, 2022

EXECUTIVE SUMMARY

After several preliminary announcements and statements of "guidance," HHS published its notice of proposed rulemaking ("NPRM") on August 4. The NPRM is complicated, perhaps, intentionally so. It has 109,195 words, 724 footnotes, and 193 pages. It references over 1,000 other documents, and it incorporates by reference dubious "standards of care," pronounced by radicalized medical bodies like the World Professional Association of Transgender Health, the American Academy of Pediatrics, the Endocrine Society, and others.[1]

HHS's NPRM, in combination with the EEOC's interpretation of Title VII, constitutes the government's most radical assault on the religious liberty of Catholic hospitals, physicians, and employers along with their insurers and third-party administrators ("TPAs") since Oregon all but forbade Catholic schools in 1922. *See Pierce v. Society of Sisters*, 268 U.S. 510 (1925).

What was HHS's prequel to the NPRM?

The government has issued too many statements, "guidances," executive orders, "reinforcements," and regulations to describe them all here. Three are particularly important understand the 2022 NPRM.

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[1] James M. Cantor, *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, J. OF SEX & MARRIAGE 307 (December 14, 2019); Julia Mason and Leor Sapir, *The American Academy of Pediatrics' Dubious Transgender Science*, WALL STREET JOURNAL (August 17, 2022) (https://www.wsj.com/articles/the-american-academy-of-pediatrics-dubious-transgender-science-jack-turban-research-social-contagion-gender-dysphoria-puberty-blockers-uk-11660732791); Leor Sapir, *A New Low: Advocates of Pediatric gender transtition publish a fatally flawed study purporting to debunk the social-transition hypothesis*, CITY JOURNAL (August 5, 2022) (al); Leor Sapir, *A Cause, Not a Cure*, CITY JOURNAL (May 20, 2022) (https://www.city-journal.org/new-study-casts-doubt-on-gender-affirming-therapy); Daryn Ray, *The mental health establishment is failing trans kids,* WASHINGTON POST (November 24, 2021.

(1) By the time of the government's March 31, 2022 observance of International Transgender Visibility Day, HHS and two HHS-related agencies published statements relevant to the NPRM: HHS's *Notice and Guidance on Gender Affirming Care, Civil Rights, and Patient Privacy*("HHS Guidance"), OASH's *Gender-Affirming Care and Young People* ("OASH Guidance"), and NCTSN's *Gender-Affirming Care is Trauma-Informed Care* "(NCTSN Guidance").[2] These statements introduced a new term, "gender-affirming care" "GAC" in place of what HHS's 2016 regulation called "gender transition services." But GAC means more. It includes not only cross-sex hormones and genital mutilating surgeries, but also puberty blockers, gender-conforming cosmetic surgeries, social affirmation, an examination of conscience, and reform regarding one's biases.

(2) On July 11, 2022—eighteen days after the *Dobbs* decision—HHS, through its Center for Medicare and Medicaid Services, issued its *Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss.* This "reinforcement" advised hospitals and physicians that the Emergency Medical Treatment and Labor Act required them to "stabilize" "people in labor" by, *inter alia*, performing abortions. It stated:

> If a physician believes that a pregnant patient presenting at an emergency department is experiencing an emergency medical condition as defined by EMTALA, and that abortion is the stabilizing treatment necessary to resolve that condition, the physician **must** provide the treatment.

In response to those states restricting access to abortion, it pointedly stated:

> When a state law prohibits abortion and does not include an exception for the life and health of the pregnant person—or draws the exception more narrowly than EMTALA's emergency medical condition definition—**that state law is preempted**.

In anticipation of the likelihood that Catholic hospitals require their physicians to comply with the Ethical and Religious Directive's proscription of abortion, HHS's

[f]"OASH" is the Office of the Assistant Secretary of Health, led by Surgeon General Rachel Levine. "NCTSN" is the National Child Traumatic Stress Network."

"reinforcement" noted that EMTALA has an anti-retaliation provision that protected physicians who facilitated abortion in compliance with the Act.

The U.S. District Court in Lubbock enjoined HHS "reinforcement" because it was dishonest. *Texas v. Becerra*, no. 5:22-CB-185-H, 41 (N.D. Tex. August 23, 2022). EMTALA specifically defines an "emergency medical condition [as] placing the health of . . . a pregnant woman . . . **or her unborn child** . . . in serious jeopardy." 42 U.S.C. § 1395dd(e)(1)(A)(i). EMTALA specifically states that the stabilization of a pregnant woman's emergency medical condition is accomplished only by "delivery of the unborn child and the placenta." (Emphasis added).

While not directly applicable to the NPRM, HHS's contemporaneous and widely-published false announcement that EMTALA requires hospitals to perform emergency abortion shows the lengths the present administration will go to create a post-*Dobbs* federal right to abortion. HHS's "guidance" to pharmacies two days later does the same.

(3) On July 13, 2022, HHS issued *Guidance to the Nation's Retail Pharmacies* advising them that Section 1557, the same provision of the Affordable Care Act that serves as the statutory foundation for the NPRM, prohibits discrimination on the basis of sex and that "sex" includes pregnancy and "medical conditions related to pregnancy." It then provided a series of five examples where a pharmacy would violate Section 1557 if it did not stock and sell the abortion pills--mifepristone, misoprostol, and methotrexate—and various abortifacients.

If ACA § 1557 and Title VII both prohibit discrimination based on "sex," how does the NPRM define "sex"?

While the NPRM's definition section, Rule 92.4, does not define "sex," *see* NPRM 47,911-12, Rule 92.101(b) states that "sex" includes "sex stereotypes, sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; and gender identity," *id.* at 47,916. "Sex" also includes "sex assigned at birth [and] gender otherwise recorded." *Id.* at 47,865. As discussed in the abortion section below, "sex" not only includes "pregnancy or related conditions" but also "termination of pregnancy." NPRM at 47,878; 45 C.F.R. § 86.40(b)(1), (b)(4), (b)(5). HHS explains that the term "sex characteristics" is used "because discrimination based on anatomical or physiological sex characteristics (such as genitals, gonads, chromosomes, hormone function, and brain development/anatomy) is inherently sex-based." NPRM at 47,858.

Who's covered?

The 2022 NPRM applies to every "health program or activity, any part of which receives Federal Financial assistance ("FFA"), directly or indirectly, from [HHS]." *Nondiscrimination in Health Programs and Activities*, Fed. Reg. 47,824, 47,842, 47,911 at § 92.2(a)(1) (August 4, 2022) ("NPRM").[3] FFA includes "pass through funds" from HHS administered through state agencies. *Id.* at 47,844. FFA comes in many forms including "any grant, loan, credit, subsidy, contract . . .or other arrangement by which the Federal Government, directly or indirectly provides assistance." *Id.* at 47,912, § 92.4.

Entities to which the rule applies are called "covered entities." Covered entities include hospitals, health clinics, **health insurance issuers**, physician's practices, pharmacies, community-based health care providers, nursing facilities, residential or community-based treatment facilities, and other similar entities. *Id.* at 47,844. Covered entities also include **TPAs** of self-funded group health plans. *Id.* at 47,845.

How can dioceses and other employers be bound when the NPRM says they are not?

Rule 92.2(b) within the NPRM states that the NPRM "shall not apply to any employer with regard to its … provision of employee health benefits." *Id.* at 47,911. While this is technically correct, it is misleading. The NPRM binds Catholic dioceses, religious institutes, Catholic colleges, other Catholic ministries, and Catholic-owned businesses in three ways. First, employers can only provide health plans through the engagement of either an insurance company providing group health insurance or a TPA administering a self-funded plan. By binding insurers and TPAs with its coverage mandates, the NPRM forecloses all morally licit health plan options for Catholic dioceses and other employers *Id.* at 47,877.

What's mandated?

The NPRM requires insurers and TPAs to *cover* and physicians and hospitals to *perform* chemical and surgical abortion, broadly-defined "gender-affirming care" for transgender persons, and "gender-affirming care" in the form of castration for "gender non-conforming" persons who identify as eunuchs. *See* NPRM at 47,918, § 92.207(b)(4) and (5), 47,858; World Professional Association of Transgender Health, STANDARDS OF CARE FOR THE HEALTH OF TRANSGENDER AND GENDER DIVERSE PEOPLE S88-S92 (version 8,2022) ("WPATH Standards") and discussion below.

What is "gender-affirming care?

Notwithstanding that "gender-affirming care" is one of the NPRM's two principal mandates, it is not defined in the NPRM's definition section. *See Id.* at 47,211, § 92.4. Indeed, the

[3] While HHS's NPRM is intended to serve as a template for other federal agencies, [citation], it "does not apply to health programs of activities receiving Federal financial assistance from other Federal agencies." NPRM at 47,842.

precise scope of GAC services is never stated. The NPRM partially defines GAC in footnote 139 as including, but not limited to "counseling, hormone therapy, surgery, and other services designed to treat gender dysphoria or support gender affirmation or transition." The NPRM makes clear that GAC subsumes "gender-affirming health services," and "transition-related care." *Id.* at n. 139. It includes the full "range of care that transgender individuals (including those who identify [as] nonbinary or gender nonconforming) may seek to treat gender dysphoria and support gender transition or affirmation. *Id.* at n. 455.

The prequel statements by HHS and its affiliates provide further content regarding the scope of GAC. The OASH Guidance, for example, includes this chart:

Affirming Care	**What is it?**	**When is it used?**	**Reversible or not**
Social Affirmation	Adopting gender-affirming hairstyles, clothing, name, gender pronouns, and restrooms and other facilities	At any age or stage	Reversible
Puberty Blockers	Using certain types of hormones to pause pubertal development	During puberty	Reversible
Hormone Therapy	Testosterone hormones for those who were assigned female at birth Estrogen hormones for those who were assigned male at birth	Early adolescence onward	Partially reversible
Gender-Affirming Surgeries	"Top" surgery – to create male-typical chest shape or enhance breasts "Bottom" surgery – surgery on genitals or reproductive organs Facial feminization or other procedures	Typically used in adulthood or case by-case in adolescence	Not reversible

The OASH Guidance states that "early gender-affirming care is crucial" for children and adolescents. It also provides an extended discussion explaining that "social affirmation" is an important part of GAC:

> A safe and affirming healthcare environment is critical in fostering better outcomes for transgender, nonbinary, and other gender-expansive children and adolescents. Medical and psychosocial gender affirming healthcare practices have been demonstrated to yield lower rates of adverse mental health outcomes, build

> self-esteem, and improve overall quality of life for transgender and gender diverse youth. Familial and peer support is also crucial in fostering similarly positive outcomes for these populations. Presence of affirming support networks is critical for facilitating and arranging gender affirming care for children and adolescents. Lack of such support can result in rejection, depression and suicide, homelessness, and other negative outcomes.

OASH Guidance.

The NCTSN Guidance is even more specific. It offers many "practical suggestions for what you can do" while providing no clear antecedent for "you." These include:

- **Believe and validate youth when they share their gender identities** with you by always using and validating the names, pronouns, and identities that youth share with you, even if those change while they are exploring their identities. Many children are aware of their own gender identity as early as 3-5 years old, although it is also common for children to explore gender identity at later ages. Cisgender children are trusted to know and understand their gender, and social norms and customs validate their identities regularly. TGI youth deserve the same trust and validation. As parents, caregivers, and providers, you are responsible to communicate this validation by actively affirming their identities. . . .

- **Proactively seek out and build relationships with local service providers who specialize in care for TGI youth in order to create a supportive network and provide reliable referrals to TGI youth and their families.** These services are not accessible in every community, and virtual/telehealth connections may be necessary to create a supportive network. Identify the nearest places to you where youth and their families can access this care, including resources to help address added travel burdens or reliable internet access limitations. . . .

- **Create space for youth to explore the fullness of their gender and other cultural identities without fear of judgment or harm.**

- **Assist youth, parents, and caregivers with family safety planning by helping them create a "safe folder."** This folder can include letters from providers (e.g., medical, mental health) and community members (e.g., neighbors, spiritual leaders, school representatives) communicating that

> parents/caregivers are not harming their child and that the child is benefitting from their care. Parents and caregivers can use this folder should they need to justify the affirming and supportive care they are providing for their child. . . .
>
> - **Keep working to recognize and shift your own biases and assumptions** by continually asking yourself questions about the power and privilege you have based on your own gender identity, sexual orientation, race, provider status, and other aspects of your intersectional identities. Support and challenge your colleagues and collaborative partners to do the same, and build spaces to explore layers of seen and unseen privilege and oppression.

NCTSN Guidance.

But this is only halfway. The real heavy lifting in defining the scope of GAC is accomplished through medical standards of care as explained in the next FAQ.

What is the relationship between the gender-affirming care mandate and standards of care defined by WPATH, the American Academy of Pediatrics, and other medical societies?

The NPRM repeatedly includes statements to the effect that GAC "should . . . follow professional standards of care" and that clinically appropriate GAC "is based on generally accepted scientific or medical standards." *See* NPRM at 47,867; 47,868; 47,894. HHS Guidance invokes the "significant majority of expert medical associations." OASH Guidance cites to "additional information" provided by the Endocrine Society's "Practice Guideline", the American Academy of Pediatrics' ("AAP") standards, and the WPATH Standards. NCTSN's Guidance refers to the "standards of care" defined by WPATH, the American Academy for Child and Adolescent Psychiatry, and the AAP. WPATH's standards of care are now in their eighth version and have been translated in nineteen languages. WPATH, headquartered in Illinois, is supported in part by the billionaire Pritzker family of Illinois, led by Jennifer Pritzker, a transgender woman, by Jennifer's brother, J. B. Pritzker, the Governor of Illinois, and by their family's Tawani Foundation.[4] WPATH also receives substantial donations from George Soros's Open Society Foundation and John Stryker's Arcus Foundation both of which support transgender activism.[5] As indicated in the articles cited on footnote 1, *supra*, WPATH and the other medical societies

[4] Jennifer Bilek, *The Billionaire Family Pushing Synthetic Sex Identities (SSI),* THE TABLET (June 14, 2022) (https://www.tabletmag.com/sections/news/articles/billionaire-family-pushing-synthetic-sex-identities-ssi-pritzkers).

[5] *See generally* websites of these foundations.

have adopted the radical GAC agenda. They suppress dissent[6] and, when formulating GAC standards, they rely on shoddy studies questioned even by WPATH's former president and by the founder of the first pediatric transgender clinic.[7] WPATH even relies upon pure anecdotal statements of eunuchs collected on www.eunuch.org, a website that links to violent and pornographic eunuch fiction. WPATH Standards, S88.

As just one example, here's what WPATH states is the standard of care for GAC:

- **Puberty** blockers for children
- **Cross**-sex hormones
- **Genital** mutilating surgeries (top and bottom)
- **Feminizing** & masculinizing cosmetic surgeries
- **Psychotherapy**
- **Ban** on conversion therapy
- **Testicular** tucking
- **Breast** binding/pads
- **Penile** prosthesis
- **Voice** modification
- **Reproductive** healthcare for impotent and sterile persons
- Broad **social** support
- **Chemical** and surgical castration of persons identifying as eunuchs
- **Prohibition of counseling to align with patient's biology** (aka "conversion therapy"), *id*., S7, S53 (statement 6.5), S176-77 (statement 18.10)

See generally WPATH Standards.

[6] *See, e.g.,* Abigail Anthony, *American Academy of Pediatrics Accused of Censoring Concerns about 'Gender-Affirmative Care'*, NATIONAL REVIEW (July 29, 2022). *(*https://www.nationalreview.com/2022/07/american-academy-of-pediatrics-accused-of-censoring-concerns-about-gender-affirmative-care/).

[7] *See* n. 1, *supra; see also* articles and studies collected at the Catholic Women's Forum of the Ethics and Public Policy Center's website, "Person and Identity," here: https://personandidentity.com/resources/medical-resources/research-and-evidence/.

The institutional capture of these medical societies and the radicalization of GAC standards of care have major implications beyond defining the scope of the NPRM's mandate. Professional standards of care are the primary criteria for determining whether hospitals should be accredited and whether physicians should be licensed and whether both should be found liable for professional malpractice.

Does "gender-affirming care" include castration for eunuchs?

Yes. The NPRM prohibits discrimination on the basis of "sex" and says that "sex" includes "sex characteristics" including "gonads." "Gonads" is a new category that was not included in HHS's 2016 Rule. HHS also limits its references to "transgender" persons in favor of the more expansive term, "gender-nonconforming" persons. It explains that it does this because "the form of discrimination [that] may impact a range of individuals, including [those who] do not identify as transgender." *Id.* at 47,865. HHS appears to have expanded its list of protected classifications to include "gonads" because it anticipated the publication of version 8 of the WPATH Standards, S88-S92 that includes a new entire chapter on eunuchs, as an additional category of "gender diverse individuals" with their own "gender identity" and in need of chemical or surgical castration as "medically-necessary gender-affirming care." *Id*. at S88.

How does the NPRM mandate coverage and performance of chemical and surgical abortion?

ACA section 1557 prohibits discrimination on the basis of sex. *See also* NPRM at 47,916, § 92.101(1)(a). The NPRM defines "sex" broadly and as including "pregnancy or related condition." NPRM at 47,914, § 92.8(b). NPRM's commentary states that "pregnancy or related condition" means, *inter alia*, "termination of pregnancy" because a Title IX regulation says this. NPRM at 47,878; 45 C.F.R. § 86.40(b)(1), (b)(4), (b)(5).

What could a prohibition of discrimination on the basis of "termination of pregnancy" possibly mean except discrimination arising from the refusal to cover or perform abortion? HHS's other actions confirm this reading for six reasons.

First, the NPRM includes an extended discussion as to why it can incorporate the Title IX regulation stating that sex discrimination also means abortion discrimination while refusing to incorporate the Title IX abortion neutrality provision.[8] NPRM at 47,879-80. This would be unnecessary unless HHS intended to mandate abortion coverage and performance.

[8] Title IX's abortion neutrality provision that states:

Second, in 2016, HHS's Rule also forbade sex discrimination defined as "termination of pregnancy." Because of this a network of Catholic hospitals, called Franciscan Alliance, challenged the 2016 Rule to avoid this abortion performance mandate. *Franciscan Alliance v. Burwell*, 227 F.Supp. 3d 660, 690-91 (N.D. Tex. 2016). In its 2022 NPRM, HHS admits that the *Franciscan Alliance* court ruled that, it "was required to incorporate the language of Title IX's abortion neutrality provision" in 2016. The federal court reasoned:

> Failure to incorporate Title IX's religious and abortion exemptions nullifies Congress's specific direction to prohibit only the ground proscribed by Title IX. That is not permitted. *Corley*, 556 U.S. at 314, 129 S.Ct. 1558. By not including these exemptions, HHS expanded the "ground prohibited under" Title IX that Section 1557 explicitly incorporated.

Id. Notwithstanding this ruling, HHS now says it will not abide with that holding because "we disagree with that decision, which does not bind this new rulemaking." NPRM at 47,879.

Third, HHS promises to "robustly" enforce its NPRM, in part, by acting in close coordination with the EEOC. *Id.* at 47,868, 47,877. But the EEOC enforces Title VII—not ACA § 1557—and Title VII, as amended by the Pregnancy Discrimination Act, includes its own abortion neutrality provision. 42 U.S.C. § 2000e(k) ("This subsection shall not require an employer to pay for health insurance benefits for abortion" except for the life of the mother "or except where medical complications have arisen from an abortion."). HHS appears to wish this provision away by not even addressing it in its 193-page NPRM. It does the same with regard to a host of other restrictions preventing the government from mandating or funding abortion, including the Weldon Amendment, the Coats-Snowe Amendment, and the Church Amendment, ACA section 1302, 42 U.S.C. § 18023(b)(a)(1), (b)(1)(A(i), (b)(4), (c), and Executive Order, *Ensuring Enforcement and Implementation of Abortion Restrictions in the Patient Protection and Affordable Care Act* 13535 (2010). *See* NPRM at 47,842, 47,879.

> Nothing in this chapter shall be construed to require or prohibit any person, or public or private entity, to provide or pay for any benefit or service, including the use of facilities, related to an abortion. Nothing in this section shall be construed to permit a penalty to be imposed on any person . . . because such person . . . is seeking or has received any benefit or service related to a legal abortion.

20 U.S.C. § 1688.

Fourth, even though HHS was a party in the *Catholic Benefits Association* case styled as *Religious Sisters of Mercy v. Azar*, 513 F.Supp.3d 1113, (D. N.D. 2021), it simply ignored the ruling therein that recognized that HHS 2016 Rule that prohibited discrimination on the basis of termination of pregnancy did not mandate abortion coverage or services because HHS 2020 Rule required incorporation Title IX's abortion neutrality provision into the 2016 Rule. *Id.*, 513 F.Supp.3d, 1113, 1124-25, 1135.

Fifth, as previously explained, HHS provided guidance to pharmacies on July 13, 2022 that took the position that Section 1557 required them to stock and sell abortion pills or otherwise be found to have discriminated on the basis of sex. This guidance not only evidence's HHS's view that Section 1557 mandates abortion but chemical abortion in addition to surgical abortion.

Finally, when the Fifth Circuit reviewed HHS 2016 rule that forbade discrimination on the basis of termination of pregnancy, it recognized that this was an abortion mandate. *Franciscan Alliance v. Becerra*, 2022 WL 3700044 (5th Circ. August 26, 2022). Because it burdened the plaintiff's religious exercise in violation of the Religious Freedom Restoration Act, it enjoined HHS from enforcing this abortion mandate against the plaintiffs in that case. *Id.*

Does the NPRM specifically target Catholic healthcare and specifically prohibit Catholic hospital's adherence to the ERDs?

Yes. The ERD includes an anti-ERD provision. It states: "A covered entity must not . . . limit a healthcare professional's ability to provide health services on the basis of . . . gender identity . . . if such . . . limitation has the effect of excluding individuals from [a] health program or activity." *Id.* at 48,866; 47,918, § 92.206(b)(2.) Lest there be any doubt that HHS views its NPRM as trumping the USCCB's ERDs, one need only review the authorities cited in footnotes 216 and 217 complaining about the problem Catholic hospitals' monopoly is certain rural communities and Catholic healthcare's overall market share. HHS's thinly-veiled analysis regarding the problem of Catholic healthcare states:

> There are an increasing number of communities in the United States with limited options to access health care from non-religiously affiliated health care providers. As a practical matter, then, many patients and their families may have little or no choice about where to seek care, particularly in exigent circumstances, or in cases where the quality or range of care may vary dramatically among providers. Moreover, health care consumers are not always aware that the health care entities from which they seek care may be limited in the care they provide. Incorporation of Title IX's religious exception would therefore seriously

> compromise Congress's principal objective in the ACA of increasing access to health care.

NPRM at 47,840-41.

Does the NPRM have include a religious exemption?

No. The NPRM includes an extended discussion why HHS can incorporate into ACA § 1557 the sex discrimination provision in Title IX while leaving behind its religious organization exemption. *Id.* at 47,840-41. It also states that it can only evaluate whether the Religious Freedom Restoration Act requires religious exemption on a case-by-case basis. *Id.* at 47,841.

Does the NPRM permit individual physicians to exercise their professional judgment?

No. The NPRM states: "a provider's belief that gender transition or other gender-affirming care can never 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." *Id.* at 47,867; 47,917, § 92.206(c).

Will the permanent injunction won by the Catholic Benefits Association against HHS 2016 Rule protect CBA's members and future members from the 2022 NPRM?

The CBA's earlier injunction should protect CBA members and future members from the new GAC mandate but not necessarily from the new abortion mandate. Here's why.

The CBA's 2021 permanent injunction enjoins HHS and EEOC "from interpreting or enforcing Section 1557 [or Title VII] **or any implementing regulations thereto** against the CBA and its [present and future] members . . . And their respective health plans and insurers or TPAs . . . in a manner that would require them to perform or provide insurance coverage for **gender-transition procedures**." *Religious Sisters of Mercy v. Azar*, 513 F.Supp.3d 1113, 1153,54 (D. N.D. 2021). The February 19, 2021 Order for Entry of Judgment in the CBA cases states: "As used in this order, the term, **'gender-transition procedures'** includes surgery, counseling, provision of pharmaceutical, or other treatments sought in furtherance of gender transition." (Emphasis added).

If the abortion mandate remains within the final rule, CBA will file suit to protect its members.