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Expanding Conscience, Shrinking Care: The Crisis in Access to Reproductive Care and the Affordable Care Act's Nondiscrimination Mandate

ABSTRACT. *Hobby Lobby* represents a high-water mark in a decades-long movement to facilitate conscientious objection at both the federal and state levels. In addition, the number of conscientious objectors has grown because hospital consolidation has increased the dominance of the Ethical and Religious Directives, which limits the care provided by Catholic hospitals. But a little noticed provision of the ACA—Section 1557—expresses new congressional commitment to equality in access to care. Section 1557 incorporates into federal healthcare law a robust definition of sex discrimination that may limit conscientious objectors' ability to deny patients necessary reproductive health services as well as information about their health status. The law's nondiscrimination provision requires a more equitable balance between the religious liberty of medical providers and patients' rights to care and information.

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INTRODUCTION

Tamesha Means was just eighteen weeks pregnant when her water broke.¹ She rushed to the only hospital in the county, Mercy Health Partners Muskegon, Michigan.² But the doctors there did not tell her that because of her condition, the fetus would not survive.³ They did not tell her that continuing with the pregnancy would pose serious health risks,⁴ and they did not tell her that the safest choice would be to terminate the pregnancy.⁵ Instead, they sent her home and told her to see her doctor in a week or so.⁶

Means returned to the hospital the next day. She was bleeding this time, with painful contractions, and a fever.⁷ The doctors suspected that Means was suffering from a bacterial infection that could be fatal.⁸ But again, they sent her home.⁹ Later that day, Means returned to the hospital a third time—now with unmistakable signs of infection.¹⁰ The doctors were preparing, yet again, to turn her away when she began to deliver.¹¹ The baby died immediately after delivery,¹² and Means was left sick with a potentially deadly infection.¹³

Why did Mercy Health Partners refuse to provide care to Means? The hospital adhered to the Ethical and Religious Directives for Catholic Health Care Services.¹⁴ The Directives are seventy-two numbered instructions that outline

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1. Complaint at 2, 4, Means v. U.S. Conference of Catholic Bishops (E.D. Mich., Apr. 16, 2014) (No. 2:13-CV-14916).
 2. *Id.* at 2.
 3. *Id.*
 4. *Id.*
 5. *Id.*
 6. *Id.*
 7. *Id.* at 2, 6.
 8. *Id.* at 6.
 9. *Id.* at 2.
 10. *Id.* at 2-3.
 11. *Id.* at 7.
 12. *Id.*
 13. *Id.*
 14. *Ethical and Religious Directives for Catholic Health Care Services*, U.S. CONF. CATH. BISHOPS (5th ed. 2009), <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf> [<http://perma.cc/B5C7-28GW>] [hereinafter *Directives*].

the ethical and religious imperatives for Catholic healthcare providers.¹⁵ As relevant to Means's case, the Directives specify:

- Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted.¹⁶
- The free and informed health care decision of the person . . . is to be followed so long as it does not contradict Catholic principles.¹⁷
- A Catholic health care institution should provide prenatal, obstetric, and postnatal services for mothers and their children in a manner consonant with its mission.¹⁸

The Directives instructed Mercy Health Partners not to facilitate miscarriage for Tamesha Means, even if there was no chance that the pregnancy would result in a viable live birth.¹⁹ The Directives also prevented the hospital's physicians from informing Means about treatment options that were inconsistent with the Directives but might be available elsewhere.²⁰ Compounding the problem, Means was given no indication that Mercy Health Partners, as a

15. Directive 5 states: "Catholic health care services must adopt these Directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel." *Id.* at 12.

16. *Id.* at 26. Directive 45 states in full: "Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo. Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation. In this context, Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers." *Id.* Directive 45's prohibition of "material cooperation" with respect to pregnancy termination services directs Catholic health care services to refrain from informing patients about the availability of and/or need for pregnancy termination procedures if the fetus is not viable.

17. *Id.* Directive 27 does not allow Mercy Health Partners to provide a patient with information not deemed "morally legitimate," such as pre-viability pregnancy termination, even when such information is necessary to safeguard the patient's health. *Id.*

18. *Id.* (Directive 44).

19. *Id.* at 26.

20. *See id.*

religiously affiliated hospital, might withhold information, so she continued to seek treatment from the same doctors as she grew sicker.²¹

Tamesha Means's story is not unique. Catholic hospitals provide fifteen percent of hospital beds in the United States, and an estimated one in six Americans receives medical treatment at a Catholic hospital each year.²² Because these hospitals both restrict the services they provide and may not inform patients about those restrictions, many hospital visitors may not even know that a hospital has a religious affiliation or that the Directives adopted by such hospitals constrain treatment, referral options, and the provision of information. Further, the Directives prevent physicians who wish to provide comprehensive care to their patients from doing so.²³

This Note explores women's access to healthcare in the contemporary landscape of hospital consolidation and the expansion of medical refusals. In recent years, conscience clauses have increasingly enabled religious hospitals to refuse reproductive care to their patients. Access to reproductive care has been further compromised by an unprecedented wave of mergers between religious and nonsectarian hospitals. These mergers have spread the Directives to more and more hospitals across the country. These two trends together have limited women's access to necessary reproductive care, as well as to critical information about their health.

But there is a remedy. In the text of the Affordable Care Act (ACA), Congress expressed a novel commitment to nondiscrimination in healthcare, which, for the first time, may recognize as sex discrimination the kinds of refusals of health status information and reproductive care that have increasingly

21. *Id.*

22. Jonathan Cohn, *Unholy Alliance*, NEW REPUBLIC (Feb. 22, 2012), <http://www.newrepublic.com/article/politics/magazine/100960/catholic-church-hospital-health-care-contraception> [<http://perma.cc/HR2E-UL22>].

23. For example, Dr. Michael Demos, a physician at Mercy Regional Medical Center, the sole hospital in Durango, Colorado, saw a patient with a family history of Marfan syndrome. Letter from Sara J. Rich, Staff Attorney, Am. Civil Liberties Union of Colo., to D. Randy Kuykendall, Interim Div. Dir., Colo. Dep't of Pub. Health and Env't (Nov. 13, 2013), <http://aclu-co.org/wp-content/uploads/files/2013-11-13%20CDPHE-Rich.pdf> [<http://perma.cc/H5ED-U5X4>]. Because of the "extremely high mortality rate for pregnant women with Marfan syndrome" due to the potential for dilation and rupture of the aorta, the American College of Cardiology and the American Heart Association recommend pregnancy termination if the aorta is dilated beyond four centimeters. *Id.* Dr. Demos accordingly recommended an echocardiogram to determine the aorta size. *Id.* Upon learning of this recommendation (and the eventuality to which it could lead—an abortion), the Chief Medical Officer responded that the hospital would "provide education to all our employed providers, reminding them that they should not recommend abortion—even to patients who may have serious illnesses," and that Mercy Regional medical staff are "precluded . . . from providing or recommending abortion . . ." *Id.*

taken hold across the country. The ACA requires us to strike a better balance between the interests of religious liberty and the interests of sex equality in access to healthcare.

The United States is at an inflection point in deciding to what extent the law will allow religious claims to trump other rights and interests. Controversial conscience claims aired in the Supreme Court last term in *Burwell v. Hobby Lobby*²⁴ have received widespread attention. However, Part I illustrates another conflict playing out more quietly in healthcare across the country: the rights of patients to safe and effective medical treatment and information are colliding with the religious liberty of Catholic healthcare providers to withhold services and information.²⁵ Part I shows that federal and state laws have steadily expanded to license medical refusals by more entities that provide and pay for healthcare. Furthermore, this Note is the first to demonstrate that the broadening Directives, which place higher limits on the care available at Catholic and Catholic-affiliated hospitals, have matched the statutory expansion of rights to medical refusals at every step.

Recent developments in the healthcare market have, in the wake of the ACA, exacerbated the problem of medical refusals. Anxiety among healthcare providers about their fate in the post-ACA world has accelerated consolidation to record levels. Today, integrated-care networks incentivized by the ACA aim to wring out excess costs as hospitals try to regain pricing power.

As Part II demonstrates, this push to consolidate has increased the dominance of the Directives in healthcare systems across the United States. This

24. *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014) (holding that for-profit corporations, under the Religious Freedom Restoration Act (RFRA), could not be compelled to provide health insurance that includes contraceptive coverage to their employees). This case, together with other recent precedent such as *Town of Greece v. Galloway*, 134 S. Ct. 1811 (2014), has been characterized as part of a new campaign by the Roberts Court to increase the role of religion in public life. See, e.g., Linda Greenhouse, Op-Ed, *Reading Hobby Lobby in Context*, N.Y. TIMES, July 9, 2014, <http://www.nytimes.com/2014/07/10/opinion/linda-greenhouse-reading-hobby-lobby-in-context.html> [<http://perma.cc/NWN8-8TCB>]. In fact, these cases are just the most recent outgrowth of a medical refusals movement that has been developing for decades. See *infra* Part I.

25. While the question of religious objection to providing certain medications and medical procedures is related to the question of insurance coverage, these issues differ meaningfully with respect to third-party harms and the possibility of offsetting those harms. The majority in *Hobby Lobby* emphasized as central to its RFRA analysis that women whose employers refused to cover contraception could theoretically obtain coverage through the Government's preexisting accommodation for religious non-profits. *Hobby Lobby*, 134 S. Ct. at 2782. By contrast, in the context of medical refusals, a hospital's policy against certain treatment or counseling may foreclose a patient's ability to receive the necessary care. This is especially true when the hospital is a sole community provider and there are no alternative emergency care facilities in the area. For further discussion, see *infra* Part III.C.

push, together with the well-documented growth of Catholic hospital systems, means that the exemptions sought by religious healthcare providers will have a larger impact than ever before. If these two trends—the expansion of conscientious objection and the consolidation of U.S. hospitals—continue without intervention, they will lead to the dramatic reduction of services, referrals, and information for female patients regarding their reproductive care.

The trend toward expanded refusals and consolidated hospitals has, to date, vindicated only the religious liberties of healthcare providers. These interests have not been sufficiently balanced against federal commitments to access and equality for the many women affected by these refusals. However, a little-explored provision of the Affordable Care Act, lost among the high-profile challenges to the Act in *Hobby Lobby* and *King v. Burwell*,²⁶ expresses a deep commitment to antidiscrimination principles in access to healthcare. It demands a more appropriate balance between the rights of female patients seeking healthcare and information on their health status, on the one hand, and the rights of providers to conscientious refusal, on the other. The ACA's nondiscrimination provision should be taken seriously as part of the Act's broad vision of healthcare reform. That the ACA has also incentivized the contemporary merger frenzy and created a push for clinical integration, thereby extending the Directives' reach, makes it especially important that the Act's antidiscrimination commitments be allowed to take full effect.

Part III develops an account of the ACA's non-discrimination provision, Section 1557. As Part III.A shows, this provision establishes for the first time a robust definition of sex discrimination in healthcare. Section 1557 incorporates Title IX's private right of action for patients and its definition of sex discrimination, which deems pregnancy discrimination to be discrimination on the basis of sex. The ACA thus represents a paradigm shift in how we should conceive of sex equality in healthcare. Part III.B discusses how Section 1557 should be viewed as a federal counterweight to conscience protections, requiring us to reassess the balance between sex equality and religious liberty. It demonstrates how such a balance would increase access to reproductive information and potentially to underlying services without infringing on critical conscience protections. Section 1557 should be understood to limit overly broad and far-reaching refusals enabled by expanding state laws and commercial relationships that increasingly connect religious and nonsectarian hospitals. Part III.C then analyzes how this provision might be applied to emergency reproductive care and information about health status, and it chronicles Section 1557's interactions with other federal and state law.

26. No. 14-114 (U.S. argued Mar. 4, 2015) (No. 14-114).

The ACA has expanded the definition of sex discrimination in healthcare just as medical refusals compromising the reproductive rights of patients have reached their peak. This Note argues that Section 1557 can be read to challenge practices that disadvantage pregnant and pregnancy-capable patients. Such a reading of the ACA's nondiscrimination provision may challenge current practices – apparently authorized by state law and previously unchecked federal law commitments to religious liberty – that deny patients reproductive care and information. As religious refusals and hospital consolidations have expanded, together they have helped to produce a crisis in access to reproductive care. As long as these trends and their unanticipated effects remain unchecked, the antidiscrimination commitments of the ACA will remain unrealized.

I. THE EXPANSION OF CONSCIENTIOUS OBJECTION AT THE FEDERAL AND STATE LEVEL

The Supreme Court's decision in *Hobby Lobby* limits the reach of the ACA's contraceptive mandate and expands conscientious objection in the realm of reproductive rights. Some for-profit corporations may now object to providing health insurance that covers contraception. But federal and state laws have long authorized claims of religious medical refusals, a trend that has been picking up since the 1990s. These allowances have coincided with larger demands for accommodations from Catholic hospitals, as a result of the expanded exemptions set out in the Ethical and Religious Directives themselves. The growing list of restrictions on services at Catholic hospitals, combined with more expansive accommodations at the state and federal levels, has produced a healthcare landscape in which fewer and fewer hospitals provide a full range of services for women.

A. *Origins of the Conscience Clause*

Immediately after *Roe v. Wade* announced a right to abortion,²⁷ Congress responded to concerns that medical staff would have to perform abortions despite religious objections by passing the Church Amendment.²⁸ Under this Amendment, individual healthcare providers cannot be required to perform

27. 410 U.S. 113 (1973).

28. The amendment was part of the Health Programs Extension Act of 1973, Pub. L. No. 93-45. JODY FEDER, CONG. RESEARCH SERV., RS21428, THE HISTORY AND EFFECT OF ABORTION CONSCIENCE CLAUSE LAWS 2 n.3 (2005), <http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RS2142801142005.pdf> [<http://perma.cc/ASA9-ZDQP>].

abortion or sterilization procedures.²⁹ Further, the federal government cannot, as a condition of receipt of federal funds, require providers to make their facilities available for such procedures if they contravene the provider's "religious beliefs or moral convictions."³⁰ The Amendment actually protects healthcare providers on both sides of the abortion issue: it prevents entities that receive certain federal funding from discriminating against medical personnel who either perform or refuse to perform abortion or sterilization procedures.³¹ The Amendment's legacy, however, has not been so even-handed.

Immediately following the passage of the Church Amendment, these hospitals for the first time widely adopted the Directives, which helped to stake out and solidify their religious claims.³² The Directives explicitly banned birth control along with tubal ligation, artificial insemination, and abortion.³³

Now in their fifth edition, the Directives cover categories such as "The Pastoral and Spiritual Responsibility of Catholic Health Care," "The Professional-Patient Relationship," "Issues in Care for the Beginning of Life," and "Forming New Partnerships with Health Care Organizations and Providers."³⁴ "The [D]irectives sanction prenatal care and natural family planning but prohibit nearly all other reproductive services, including all other birth control methods, emergency contraception, infertility treatment, sterilization, and abortion."³⁵ In discussing "[b]eginning of [l]ife" issues, the Directives state: "Catholic health institutions may not promote or condone contraceptive practices"³⁶

Following the passage of the Church Amendment and Catholic hospitals' rapid formal adoption of the Directives, more than half of the states enacted laws mirroring the federal protections by the end of 1974.³⁷ Within four years, nearly all states had enacted such laws.³⁸ With these protections in place, the

29. 42 U.S.C. § 300a-7(b) (2012).

30. *Id.*

31. *Id.* § 300a-7(c).

32. Kevin D. O'Rourke, *Canon Law: The Ethical and Religious Directives as Particular Law*, HEALTH PROGRESS: J. CATHOLIC HEALTH ASS'N U.S. (2010), <http://www.chausa.org/docs/default-source/health-progress/92395-pdf.pdf?sfvrsn=2> [<http://perma.cc/LDQ5-W5CS>].

33. U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES 5-7 (1971).

34. *Directives*, *supra* note 14, at 2.

35. Lori R. Freedman, Uta Landy & Jody Steinauer, *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. PUB. HEALTH 1774, 1775 (2008).

36. *Directives*, *supra* note 14, at 27.

37. Rachel Benson Gold, *Conscience Makes a Comeback in the Age of Managed Care*, GUTTMACHER INST. 1 (Feb. 1998), <http://www.guttmacher.org/pubs/tgr/01/1/gr010101.pdf> [<http://perma.cc/XT85-ULGF>].

38. *Id.*

issue was dormant until the mid-1990s, when changes to the structure of the healthcare industry catalyzed new exemptions.³⁹

B. The Expansion of Federal Laws and the Ethical and Religious Directives

The Balanced Budget Act of 1997 protected two new forms of conscientious objection: (1) insurance companies administering Medicare and Medicaid benefits (payors) could now object in addition to practitioners; and (2) payors could now object to the provision of information, not just services.⁴⁰ The Act provided that Medicaid managed-care plans and Medicare Choice plans may object to providing counseling or referral services on moral or religious grounds.⁴¹ In all other contexts, Medicaid managed-care organizations are explicitly prohibited from imposing “gag rules” on doctors.⁴²

Simultaneously, the Directives underwent revisions that mirrored the congressional accommodations while also responding to market consolidation in the healthcare industry. In this period, drawing on underlying Catholic principles against “cooperation” and “scandal,” the Directives began to dictate the kinds of corporate relationships that Catholic hospitals could enter into with nonsectarian entities.⁴³

39. FEDER, *supra* note 28, at 2-3; Gold, *supra* note 37, at 1.

40. Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251. The Medicare conscience clause appears at 42 U.S.C. § 1395w-22(j)(3)(B) (2012), and the Medicaid conscience clause provision is at 42 U.S.C. § 1396u-2(b)(3)(B) (2012).

41. 42 U.S.C. § 1396u-2; 42 U.S.C. § 1395w-22(j)(3)(B); 48 C.F.R. § 1609.7001(c)(7). The Act also prohibits requiring Federal Employees Health Benefit Plan providers to discuss treatment options to which they have a religious objection. Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251.

42. Maxine M. Harrington, *The Ever-Expanding Conscience Clause: The Quest for Immunity in the Struggle Between Professional Duties and Moral Beliefs*, 34 FLA. ST. U. L. REV. 779, 784 (2007).

43. Cf. Daniel C. Maguire, *Cooperation with Evil*, in THE WESTMINSTER DICTIONARY OF CHRISTIAN ETHICS 129 (James F. Childress & John Macquarrie eds., 1986) (defining “cooperation”). Material cooperation occurs when the agent does not explicitly consent or participate, but nevertheless contributes to sin through a peripheral action. See, e.g., *What Is the Principle of Cooperation in Evil?*, NAT’L CATH. BIOETHICS CENTER, <http://ncbcenter.org/document.doc?id=139> [<http://perma.cc/P32J-C8NZ>]. Scandal occurs when the agent acts in a manner that appears to condone illicit behavior. These ideas explain not only the structure of the Directives—which ban particular practices by any doctor at the institution rather than condoning heterogeneity in Catholic-owned facilities—but also the attention that the Directives pay to associations between Catholic hospitals and nonsectarian healthcare institutions that may provide services that are not sanctioned by the United States Conference of Catholic Bishops (USCCB). Reflecting the anxiety about affiliation with nonsectarian hospitals, Benedict Ashley and Kevin O’Rourke wrote: “Catholic hospitals cooperating in [nonsectarian obstetric department practices] are in effect *handing over* all patients to a center where sterilization and perhaps even abortion will be treated as normal options or even en-

The Coats Amendment in 1996⁴⁴ and the Weldon Amendment in 2005⁴⁵ further extended federal religious accommodation. The Coats Amendment prohibited the federal government and recipients of government funding from discriminating against providers that refuse to offer training in abortion services due to religious objections.⁴⁶ The Weldon Amendment prohibited Department of Health and Human Services (HHS) appropriations from being made available to any state or local government discriminating against any healthcare entity that “does not provide, pay for, provide coverage of, or refer for abortions.”⁴⁷ This Amendment defined “health care entity” to include HMOs and insurance plans.⁴⁸ These expansions further entrenched payors into the conscientious objection system.

The expanding exemptions reached their peak in 2008, in the waning hours of the Bush Administration. Secretary of Health and Human Services Mike Leavitt adopted the so-called “Midnight Regulations” that specifically aimed to expand (or “clarify”) the definitions of “assistance” and “health care entity” in the Church Amendment.⁴⁹ The regulation expanded “assistance” to include referrals and “health care entity” to include “an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions,”⁵⁰ as well as “hospitals and other entities” such as HMOs and health insurers.⁵¹ A leaked earlier draft would have expanded the definition of “abortion” to include so-called “abortifacient” forms of contraception, though the final text did not do so.⁵² The Midnight Regulations attempt-

couraged. . . . Consequently, they should insist on cooperative arrangements which fully protect [Catholic] values.” BENEDICT M. ASHLEY & KEVIN D. O’ROURKE, HEALTH CARE ETHICS 283 (2d ed. 1982); see also Douglas NeJaime & Reva B. Siegel, Feature, *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 YALE L.J. 2516, 2567-70 (2015) (explaining how the principles of “cooperation” and “scandal” lead to forms of refusal beyond direct participation in an objected-to practice or service).

44. 42 U.S.C. § 238(n) (2012).

45. Pub. L. No. 111-8 § 508(d)(1), 123 Stat. 524, 803 (2009).

46. 42 U.S.C. § 238(n) (2012).

47. Pub. L. No. 111-8 § 508(d)(1), 123 Stat. 524, 803 (2009).

48. *Id.*

49. Ensuring that Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices In Violation of Federal Law, 73 Fed. Reg. 50,274 (Aug. 26, 2008).

50. *Id.* These definitions were first used in the Public Health Service (PHS) Act, 42 U.S.C. § 300a-7.(2006).

51. *Id.* These definitions were first used in the Weldon Amendment, *supra* note 45.

52. Cristina Page, *HHS Moves To Define Contraception as Abortion*, RH REALITY CHECK (July 15, 2008, 2:02 PM), <http://rhrealitycheck.org/article/2008/07/15/hhs-moves-define-contraception-abortion> [<http://perma.cc/6VFN-X6KM>]. This move mirrored the expan-

ed to broaden federal accommodations to match expansive state laws until the Obama Administration reversed them in 2011.⁵³ Because these regulations were reversed, federal law does not currently extend these provisions to information given to patients by their healthcare providers. The Directives, however, apply not only to the services that the U.S. Conference of Catholic Bishops' (USCCB) hospitals can provide, but also to the *information* they can provide to patients.⁵⁴

C. *The Reach of State Conscience Clauses*

Recent years have seen a wave of conscience-clause expansions at the state level, matching and sometimes outpacing the activity at the federal level. These state laws tend to allow more objections without ensuring meaningful protections for patients. Today, according to a Guttmacher Institute report, forty-six states allow individual objections to abortion; forty-four allow institutional objections; ten allow individual provider refusals of contraception; six allow pharmacist refusals of contraception; nine allow institutional refusals of contraception; seventeen allow individual refusals of sterilization services; and sixteen allow institutional refusals of sterilization services.⁵⁵ Almost all state con-

sion of the Directives to include bans on emergency contraception in the early 2000s. In 2001, the Directives were revised to address the introduction of emergency contraception. See *Directives*, *supra* note 14, at § 36; see also Anthony McCarthy, *The "Morning-After Pill," Rape Victims and Ethical and Religious Directives for Catholic Health Care Services*, LINACRE CENTRE (Sept. 2004), <http://www.linacre.org/MornAftPillMcC.htm> [<http://perma.cc/WQ2J-E2LZ>].

53. Rob Stein, *Obama Administration Replaces Controversial 'Conscience' Regulation for Health-Care Workers*, WASH. POST, Feb. 18, 2011, <http://www.washingtonpost.com/wp-dyn/content/article/2011/02/18/AR2011021803251.html> [<http://perma.cc/DTH9-2QQR>].
54. The Directives ban contraceptive practices. *Directives*, *supra* note 14. This ban, combined with discouragement of sex outside of marriage, has led some Catholic hospitals to prohibit informing HIV-positive patients about the use of condoms to prevent viral transmission. Lisa C. Ikemoto, *When a Hospital Becomes Catholic*, 47 MERCER L. REV. 1087, 1107 (1996). In New York, however, the Catholic Church and the state compromised by agreeing that patients could be referred to other agencies to receive counseling services. For further discussion, see Kathleen M. Boozang, *Deciding the Fate of Religious Hospitals in the Emerging Health Care Market*, 31 HOUS. L. REV. 1429, 1511 (1995); *Bishops to Vote on Banning Sterilization in Catholic-Controlled Hospitals*, CATHS. FOR CHOICE (June 8, 2001), <http://www.catholicsforchoice.org/news/pr/u.s.bishopstovoteonwhethertobansterilization.asp> [<http://perma.cc/UJ4A-ELDU>].
55. *Refusing To Provide Health Services*, GUTTMACHER INST. 2 (Mar. 1, 2015) http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf [<http://perma.cc/WH5D-P5PS>].

science clauses allow nurses or doctors to refuse to treat a patient even in an emergency or other time-sensitive situation.⁵⁶

The aggressive expansion of these state refusal laws began in the mid-1990s.⁵⁷ The laws broadened exemptions in two respects. First, they expanded beyond abortion and sterilization to apply to contraception,⁵⁸ then to end-of-life care, stem-cell research,⁵⁹ and even, in some cases, to any unspecified health service to which a religious or moral objection may be raised, including counseling or the provision of information to patients about their health status.⁶⁰ Second, they granted religious accommodation to more kinds of entities.⁶¹

The most sweeping new state laws extend protection to any individual involved in healthcare regarding any part of any service to which he or she objects. For example, in 2004, Mississippi enacted the Health Care Rights of Conscience Act, which extends the protection afforded to doctors and nurses to all providers, institutions, and payors.⁶² This Act typifies the latest trend by establishing “the right not to participate . . . in a health care service that violates [one’s] conscience.”⁶³ It defines health care service as “any phase of patient medical care, treatment or procedure, including, but not limited to . . . patient referral, counseling, therapy, testing, diagnosis or prognosis, research, instruction, prescribing, dispensing or administering any device, drug, or medication, surgery, or any other care or treatment rendered by health care providers or health care institutions.”⁶⁴ The Mississippi act further defines to “participate”

56. See, e.g., 745 ILL. COMP. STAT. 70/5 (1998) (Illinois); MICH. COMP. LAWS ANN. § 333.20181 (West 2013); MINN. STAT. ANN. § 145.414 (West 2013) (Minnesota); MISS. CODE ANN. § 41-107-5 (West 2012) (Mississippi); see also James A. Sonne, *Firing Thoreau: Conscience and At-Will Employment*, 9 U. PA. J. LAB. & EMP. L. 235, 273 n.245 (2007).

57. For example, North Dakota, Texas and Illinois adopted statutes mirroring the 1997 federal expansion. Gold, *supra* note 37.

58. For example, Tennessee, TENN. CODE ANN. § 68-34-104(5) (2001), Arkansas, ARK. CODE ANN. § 20-16-304(4)-(5) (2005), Colorado, COLO. REV. STAT. ANN. § 25-6-102(9) (2005), and Florida, FLA. STAT. § 381.0051(5)(2006) enacted conscience clauses that allow medical providers to refrain from providing information about contraceptives.

59. Adam Sonfield, *New Refusal Clauses Shatter Balance between Provider ‘Conscience,’ Patient Needs*, GUTTMACHER INST. (Aug. 2004), <http://www.guttmacher.org/pubs/tgr/07/3/gro70301.pdf> [<http://perma.cc/HE8J-BFRZ>].

60. See, e.g., ARIZ. REV. STAT. ANN. § 36-3205 (2014).

61. See, e.g., N.J. STAT. ANN. § 2A:65A-2 (West 2015) (“No hospital or other health care facility shall be required to provide abortion or sterilization services or procedures.”).

62. Mississippi Health Care Rights of Conscience Act, 2004 MISS. LAWS 977, 978 § 2(b)-(d) (codified at MISS. CODE ANN. § 41-107-3(b)-(d) (2014)).

63. MISS. CODE ANN. § 41-107-5(1) (2014).

64. *Id.* § 41-107-3(a).

as actions including “to counsel, advise, provide, perform, assist in, refer for, admit for purposes of providing, or participate in providing, any healthcare service or any form of such service.”⁶⁵ Moreover, it provides complete immunity from liability to healthcare providers who refuse to provide services or information.⁶⁶

D. The Directives Threaten To Increase Their Requirements and Reach

The expansion of the Directives in lockstep with the expansion of conscience protections has produced a new crisis in reproductive care. Overly broad accommodations have a slippery-slope effect, allowing more parties connected to the healthcare industry to opt out of more services and related actions. Even in the 1970s, as refusal laws were just beginning to take hold, the dangers were clear; the Iowa Attorney General cautioned that “one could eventually get to the point where the man who mines the iron ore that goes to make the steel, which is used by a factory to make instruments used in abortions, could refuse to work on conscientious grounds.”⁶⁷ This statement foreshadowed the many expansions of religious accommodation over the next several decades.

Still, predictions about the potential effect of medical refusals did not capture more recent developments, namely the collision of expanding accommodations with the widespread consolidation of healthcare providers, partially in response to the ACA.⁶⁸ Combined, these two trends create a perfect storm: not only are there more ways for Catholic hospitals and affiliated personnel and payors to object, but there are also fewer alternatives available.

In November 2014, the USCCB announced that it would update the Ethical and Religious Directives for the first time in more than a decade.⁶⁹ The revisions are targeted precisely at the rules governing Catholic hospitals' mergers with nonsectarian institutions,⁷⁰ preventing workarounds that some hospitals have tried in order to preserve patient options. The new restrictions could go so far as to limit hospitals' relationships with suppliers, such as testing labs.⁷¹

65. *Id.* § 41-107-3(f).

66. *Id.* § 41-107-7(2).

67. Opinion No. 76-3-1, 2012 WL 375882, at *6 (Iowa A.G. 1976).

68. *See infra* Part II.

69. *See* Nina Martin, *Catholic Bishops Vote To Revise Rules for Health Care Partnerships*, PROPUBLICA (Nov. 11, 2014), <http://www.propublica.org/article/catholic-bishops-weigh-tightening-rules-for-health-care-partnerships> [<http://perma.cc/V6XP-4CN7>].

70. *Id.*

71. *Id.*

The Directives, it seems, are poised to exert further control over nonsectarian healthcare entities that engage with Catholic hospitals.

II. THE RISE OF CATHOLIC HOSPITALS IN THE CONTEXT OF POST-ACA HOSPITAL MERGERS

While hospital mergers have been on the rise since the 1990s, the merger frenzy has intensified in the post-ACA healthcare landscape. Because some of the most financially successful hospital systems are Catholic, they have increased their market share significantly.⁷²

A. Post-ACA Hospital Consolidation

Since the ACA's passage, hospital consolidation has intensified.⁷³ In 2012, for example, 105 mergers and acquisitions (M&A) were reported, double the annual figures from the "pre-ACA, pre-recession" years of 2005 to 2007.⁷⁴ The consulting firm Booz & Co. predicts that the Affordable Care Act will cause 1,000 of the U.S.'s 5,000 hospitals to undergo additional M&A activity in the next five to seven years.⁷⁵

The ACA encourages consolidation in two respects. One is the unintended byproduct of shaking up the healthcare landscape; the other is an intentional effort to reduce costs. In the first respect, the ACA has spurred consolidation by empowering commercial payors to negotiate prices with healthcare providers, including hospitals,⁷⁶ which had been criticized for exorbitant costs.⁷⁷ Con-

72. Molly Gamble, *25 Largest Non-Profit Hospital Systems*, BECKER'S HOSP. REV., July 24, 2012, <http://www.beckershospitalreview.com/lists/25-largest-non-profit-hospital-systems.html> [<http://perma.cc/E3TB-SPYE>] (showing that six of the top ten largest non-profit hospital systems—Ascension Health, Catholic Health Initiatives, Trinity Health, Dignity Health, Catholic Health East, and CHRISTUS Health—and twelve of the top twenty-five—the above, plus Providence Health System, Mercy, Avera, Catholic Healthcare Partners, Bon Secours Health System, and SSM Health Care—describe themselves as Catholic).

73. See Leemore Dafney, *Hospital Industry Consolidation—Still More To Come?*, 370 N. ENG. J. MED. 198 (2014).

74. *Id.* at 198; see also *A Wave of Hospital Mergers*, N.Y. TIMES, Aug. 12, 2013, <http://www.nytimes.com/interactive/2013/08/13/business/A-Wave-of-Hospital-Mergers.html> [<http://perma.cc/2HFP-SHSZ>].

75. See Julie Creswell & Reed Abelson, *New Laws and Rising Costs Create a Surge of Supersizing Hospitals*, N.Y. TIMES, Aug. 12, 2013, <http://www.nytimes.com/2013/08/13/business/bigger-hospitals-may-lead-to-bigger-bills-for-patients.html> [<http://perma.cc/VZR4-RMW4>].

76. See SANJAY B. SAXENA ET AL., STRATEGY &, SUCCEEDING IN HOSPITAL & HEALTH SYSTEMS M&A: WHY SO MANY DEALS HAVE FAILED, AND HOW TO SUCCEED IN THE FUTURE 5-7

cerned about their leverage in negotiations, some hospital systems are responding to the ACA by seeking to expand and thereby improve their bargaining position.⁷⁸ In this respect, hospital consolidation is an unintended, though foreseeable, byproduct of the ACA.

In another respect, healthcare consolidation is explicitly part of the ACA's blueprint for reform. Some ACA programs are aimed at wringing excess costs out of the healthcare system. One such mechanism is clinical integration, which involves coordinating patient care across a "continuum" of services and platforms, both inpatient and outpatient.⁷⁹ The ACA encouraged clinical integration by providing financial incentives and support for various forms of partnership between medical providers.⁸⁰ To benefit from the ACA's perks, healthcare entities must demonstrate increased efficiency and reduced cost to patients by showing that their proposed consolidation will meaningfully integrate the two healthcare entities. An example of such integration might be reducing the number of empty hospital beds and eliminating redundant, expensive technology.⁸¹ Demonstrating such integration frequently allows consolidating hospitals to avoid antitrust scrutiny. That is, because the ACA incentivizes a particular form of merger—one that leads to clinical integration and produces cost savings—hospitals may be permitted to consolidate in ways

(2013), http://www.strategyand.pwc.com/media/file/Strategyand_Succeeding-in-Hospital-and-Health-Systems-MA.pdf [<http://perma.cc/TW9T-S4L5>].

77. See, e.g., Steven Brill, *Bitter Pill: Why Medical Bills are Killing Us*, TIME, Apr. 4, 2013, <http://healthland.time.com/2013/02/20/bitter-pill-why-medical-bills-are-killing-us> [<http://perma.cc/2VPR-JR45>].
78. SAXENA ET AL., *supra* note 76, at 5-7.
79. *Clinical Integration*, AM. HOSP. ASS'N (2013), <http://www.aha.org/content/12/12-ip-clinical-integration.pdf> [<http://perma.cc/WRM7-6HAW>]. One mechanism by which healthcare systems can achieve this kind of integration is through accountable care organizations (ACOs), which involve coordination across care providers—doctors, hospitals, and others—to provide continuous treatment to patients. *Accountable Care Organizations (ACO)*, CENTERS FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO> [<http://perma.cc/HTJ8-53KP>].
80. Most notably, the ACA incentivized the formation of accountable care organizations (ACOs). Kathleen Sebelius, *The Affordable Care Act at Three: Paying for Quality Saves Health Care Dollars*, HEALTH AFF.: BLOG (Mar. 20, 2013), <http://healthaffairs.org/blog/2013/03/20/the-affordable-care-act-at-three-paying-for-quality-saves-health-care-dollars> [<http://perma.cc/RQ2N-PJ6Q>]; Sara Rosenbaum et al., *Assessing and Addressing Legal Barriers to the Clinical Integration of Community Health Centers and Other Community Providers*, COMMONWEALTH FUND (July 15, 2011), <http://www.commonwealthfund.org/publications/fund-reports/2011/jul/clinical-integration> [<http://perma.cc/ZNE7-MCM5>].
81. *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program*, FED. TRADE COMMISSION & DEP'T JUST. (Oct. 2011), http://www.justice.gov/atr/public/health_care/276458.pdf [<http://perma.cc/6LB8-3BEN>].

that otherwise would raise red flags for the federal antitrust agencies.⁸² Hospitals therefore have increasing incentives and legal power to consolidate.⁸³

B. The Rise of Catholic Hospitals and the Ethical and Religious Directives in the Post-ACA Merger Climate

Consolidation between Catholic and nonsectarian hospitals in this environment raises new questions about both the mergers' antitrust implications and the religiosity of the merging entities. To satisfy guidance issued by the Federal Trade Commission (FTC),⁸⁴ organizations seeking to merge must often demonstrate clinical integration, as discussed above. In other words, they must show that consolidation will result in cost savings rather than monopolistic price hikes. To satisfy the USCCB, nonsectarian organizations seeking to merge with Catholic hospitals must not compromise that entity's compliance with the Ethical and Religious Directives.

In the 1994 edition, the Directives began to spell out how Catholic hospitals could and could not associate or affiliate with nonsectarian healthcare providers.⁸⁵ The revision made clear that Catholic hospitals should not form affili-

82. See, e.g., *FTC Staff Advises Rochester Physician Organization that It Will Not Recommend Antitrust Challenge to Proposal To Provide Member Physicians' Services Through "Clinical Integration" Program*, FED. TRADE COMMISSION (Sept. 21, 2007), <http://www.ftc.gov/news-events/press-releases/2007/09/ftc-staff-advises-rochester-physician-organization-it-will-not> [<http://perma.cc/3795-PDCU>].

83. The Department of Justice (DOJ) and the FTC have issued a statement about their antitrust oversight of post-ACA integration. While the statement makes clear that oversight will continue, it suggests that "clinical integration" is the magic phrase that healthcare entities must utter in order to pass muster. *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program*, FED. TRADE COMMISSION & DEP'T JUST. (Oct. 2011), http://www.justice.gov/atr/public/health_care/276458.pdf [<http://perma.cc/6LB8-3BEN>]. In its publication *Clinical Integration*, the American Hospital Association states that for their purposes:

Antitrust guidance is narrowly and technically drafted without any binding effect; as a result, caregivers can neither readily understand the guidance nor completely rely on it. The AHA has advocated for the antitrust agencies – the Department of Justice's Antitrust Division and the Federal Trade Commission – to issue more comprehensive, user-friendly guidance clearly explaining what issues must be resolved to ensure that clinical integration programs comply with antitrust law.

Clinical Integration, *supra* note 79, at 1.

84. Markus H. Meier, *Norman PHO Advisory Opinion*, FED. TRADE COMMISSION (Feb. 13, 2013), https://www.ftc.gov/sites/default/files/documents/advisory-opinions/norman-physician-hospital-organization/130213normanphoadvltr_o.pdf [<https://perma.cc/HPD8-WL4N>]; see also *Statement of Antitrust Enforcement Policy*, *supra* note 83.

85. U.S. CONFERENCE OF CATHOLIC BISHOPS, *ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES 24-27* (3d ed. 1994) (incorporating a new section called "Form-

ations or partnerships with hospitals that performed objectionable services such as reproductive care, including abortion.⁸⁶ When non-Catholic hospitals merge or affiliate with Catholic healthcare providers, they are typically asked to adopt some or all of the Directives.⁸⁷ The local bishop must approve all business partnerships involving Catholic and non-Catholic hospitals.⁸⁸ Further, the USCCB has recently pledged to revise the Directives to make them even more stringent in dictating the terms of mergers and affiliations with nonsectarian hospitals.⁸⁹

The more seamlessly the hospitals merge, the more clearly the institution can claim clinical integration.⁹⁰ However, the more integrated the two institutions, the less opportunity for heterogeneity in service offerings under the Directives. As a result, when Catholic hospitals seek to merge with nonsectarian hospitals, the post-ACA FTC guidance pushes them toward clinical integration, which then pushes the hospital to impose the Directives on the entire resulting healthcare entity. The ACA therefore discourages the merging hospitals from leaving sufficient clinical and legal separation from the Catholic hospital to allow for a full battery of services in the nonsectarian hospital.

In this way, the pairing of this antitrust treatment and the religious objection issues facilitates an ever-increasing Catholic market share. Given the commercial success of Catholic hospital systems,⁹¹ future acquisitions and mergers seem likely to increase the reach of the Directives. And the Directives' imperatives on mergers will likely become more extensive, especially after planned revisions to deal specifically with post-ACA consolidation.⁹²

ing New Partnerships with Health Care Organizations and Providers," which provides, in part, that "[a]ny partnership that will affect the mission or religious and ethical identity of Catholic health care institutional services must respect church teaching and discipline," and "[w]hen a Catholic health care institution is participating in a partnership that may be involved in activities judged morally wrong by the Church, the Catholic institution should limit its involvement in accord with moral principles governing cooperation").

86. Boozang, *supra* note 54, at 1439-40 (noting also that there may be exceptions).

87. Lois Uttley et al., *Merging Catholic and Non-Sectarian Hospitals: New York State Models for Addressing the Ethical Challenges*, 17 N.Y. ST. B.A. HEALTH L.J. 38, 38 (2012).

88. *Id.*

89. Martin, *supra* note 69.

90. Robert F. Leibenluft & Tracy E. Weir, *Clinical Integration: Assessing the Antitrust Issues*, in HEALTH LAW HANDBOOK 20-23 (Alice G. Gosfield ed., 2004), <http://uft-a.com/PDF/LeibenluftClinicalIntegrationArticle.pdf> [<http://perma.cc/9EYV-YKCU>].

91. Gamble, *supra* note 72.

92. *Bishops Approve Items on Liturgy, Ethical and Religious Directives, Cause for Canonization at General Assembly*, U.S. CONF. CATH. BISHOPS (Nov. 11, 2014), <http://www.usccb.org/news/2014/14-186.cfm> [<http://perma.cc/4XLQ-TRWZ>]; see also Martin, *supra* note 69.

Moreover, mergers can lead to restricted care even where the Catholic hospital does not acquire the other hospital. Nonsectarian hospitals seeking to buy Catholic hospitals will also have to demonstrate clinical integration. Additionally, they will run afoul of the Directives unless the acquiring entity also agrees to abide by them. Indeed, Catholic hospitals may well be able to leverage the perceived precariousness of the post-ACA marketplace to demand more from powerful merger partners.⁹³

Market-share growth likely understates the full reach of Catholic hospitals' restrictions on care. Data suggest that concerns about the increasing sway of the Directives are warranted. The market share for Catholic hospitals has been increasing over the past decade. Today there are 645 Catholic hospitals in America, together caring for one in six American patients.⁹⁴ This represents a sixteen percent increase in Catholic hospital market share from 2001 to 2011.⁹⁵ Furthermore, since 2011, the largest Catholic hospital networks have grown at least another thirty percent.⁹⁶

Market-share growth likely understates the full reach of Catholic hospitals. Because Catholic hospital systems have increasingly entered into affiliations and acquisitions of non-sectarian hospitals, hospitals that are not strictly Catholic also abide by the Directives, at least in part. Since 1990, more than 130 known affiliations involved a Catholic hospital or health system, and eighty

93. In Washington State, for example, Swedish Medical Center, a large nonsectarian system, arranged a partnership with Catholic Providence Health & Services, and adopted the Directives by ceasing to provide abortions. Deborah Oyer, Op-Ed, *Swedish-Providence Merger Limits Women's Access to Safe Abortions*, SEATTLE TIMES, Oct. 19, 2011, <http://www.seattletimes.com/opinion/swedish-providence-merger-limits-womens-access-to-safe-abortions> [<http://perma.cc/5233-2Q7K>]. Before ceasing their full ob/gyn practice, Swedish gave a donation to Planned Parenthood in an effort to keep reproductive options available for women in the area. *Id.* This gesture provides some evidence that, in a pre-ACA economic climate, Swedish may have been unwilling to enter into a deal that would have required it to cease offering reproductive options at their facilities.

94. *Facts and Statistics*, CATH. HEALTH ASS'N U.S. (Jan. 2015), <http://www.chausa.org/newsroom/facts-and-statistics> [<http://perma.cc/J4Y3-NXVH>]; *Catholic Health Care in the United States*, CATH. HEALTH ASS'N U.S. (Jan. 2013), https://www.chausa.org/docs/default-source/general-files/mini_profile-pdf [<https://perma.cc/5FLN-VTN4>]; see also Stephanie Simon, *Health-Care Overhaul Creates Dilemma for Some Catholics*, WALL ST. J., Aug. 5, 2009, <http://www.wsj.com/articles/SB124942609292506021> [<http://perma.cc/2LX7-8NLM>]; Lois Uttley et al., *Miscarriage of Medicine: The Growth of Catholic Hospitals and the Threat to Reproductive Health Care*, MERGERWATCH & ACLU 5 (2013), <https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf> [<https://perma.cc/E8M8-DCBA>].

95. Nina Martin, *The Growth of Catholic Hospitals, By the Numbers*, PROPUBLICA (Dec. 18, 2013), <http://www.propublica.org/article/the-growth-of-catholic-hospitals-by-the-numbers> [<http://perma.cc/U6BU-5DWQ>].

96. *Id.*; see also Uttley et al., *supra* note 94, at 5 tbl.1, fig.2 (comparing Catholic hospital growth rates between 2001 and 2011 with the growth rates of other kinds of hospitals).

percent of those were between Catholic and non-Catholic organizations.⁹⁷ This phenomenon manifests in the widening discrepancy between religious hospitals and hospitals that are affiliated with or operated by Catholic healthcare systems. In 1976, the percentage of all religious or religiously affiliated hospitals that were affiliates (rather than religious hospitals themselves) was fourteen percent; today it is twenty-nine percent.⁹⁸

Religiously affiliated hospitals most dramatically demonstrate the post-ACA trend toward consolidation and clinical integration.⁹⁹ This subset of hospitals will likely continue to grow as nonsectarian and Catholic hospitals feel more pressure to merge in the uncertainty of the post-ACA market. Nonsectarian hospitals that become affiliated with the USCCB will likely be increasingly required to abide by the Directives because of the clinical integration needed to pass muster under antitrust laws. Nonsectarian hospitals may further compromise on reproductive care by accepting mergers or acquisitions with religious stipulations as a means of survival.¹⁰⁰

97. *Is There Room for Conscience Without Compromising Access?*, KAISER FAMILY FOUND. 2 (1997), <http://kaiserfamilyfoundation.files.wordpress.com/1997/10/conscienceqa.pdf> [<http://perma.cc/J4EU-PYA6>].

98. These figures are calculated from data compiled by Sara Beazley & Kim Garber, AHA Resource Center (Mar. 18, 2012) (on file with author).

99. *Id.*

100. The issues raised by hospital consolidation are further exacerbated by other recent trends. The reproductive rights landscape has greatly changed. The number of abortion providers reached its peak of 2,908 in 1982. Stanley K. Henshaw, *Abortion Incidence and Services in the United States, 1995-1996*, 30 *FAMILY PLANNING PERSP.* 263, (1998), <http://www.guttmacher.org/pubs/journals/3026398.pdf> [<http://perma.cc/86XT-CVVW>]. By 1992, that number had fallen by fifty-one percent. *Id.* Today most abortions are performed outside of hospital settings. Rachel Jones et al., *Abortion in the United States: Incidence and Access to Services, 2005*, 40 *PERSP. ON SEXUAL AND REPROD. HEALTH* 6, 6 (2008).

At the same time, however, the number of non-hospital abortion providers in the U.S. fell thirty-eight percent between 1982 (its peak) and 2005. Rachel K. Jones & Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States, 2008*, 43 *PERSP. ON SEXUAL & REPROD. HEALTH* 41, 41 (2011). An estimated fifty-four additional clinics have closed as a result of state restrictions on abortion providers since 2010. Laura Bassett, *Anti-Abortion Laws Take Dramatic Toll on Clinics Nationwide*, HUFFINGTON POST (Sept. 25, 2014), http://www.huffingtonpost.com/2013/08/26/abortion-clinic-closures_n_3804529.html [<http://perma.cc/TE4D-ALDU>]. Clinic closures mean that eighty-seven percent of United States counties do not currently have an abortion provider. Rachel K. Jones & Megan L. Kavanaugh, *Changes in Abortion Rates Between 2000 and 2008 and Lifetime Incidence of Abortion*, 117 *OBSTETRICS & GYNECOLOGY* 1358, 1366 (2011). The decrease in nonhospital abortion providers increases the importance of access to hospital reproductive services.

III. THE AFFORDABLE CARE ACT'S COMMITMENT TO NONDISCRIMINATION PRINCIPLES

While conscience claims have expanded and healthcare entities continue consolidating in the wake of the ACA's passage, parts of the Act itself reflect a profound commitment to principles of nondiscrimination. Its relatively unexamined nondiscrimination provision, Section 1557, seeks to expand the rights of all patients to equal healthcare free from discrimination. Section 1557 specifically protects women's rights to equal healthcare in ways that conflict with the current restrictions on reproductive care access. Section 1557 broadens the federal definition of sex discrimination in healthcare. It is perhaps not surprising that this Act—which sought to federalize rights to healthcare and had, as part of its blueprint for reform, included incentives for mergers and integrated care—should also expand affirmative patient rights, both to guarantee citizens' rights to care and to offset the potential effects of merger activity spurred by the ACA. So the seeming tension between the ACA's effects on the provision of reproductive care and its nondiscrimination commitments should not undermine claims about the ACA's robust nondiscrimination commitments. Indeed, until these nondiscrimination guarantees are realized, the ACA's promises remain unfulfilled.

The potential reach of Section 1557 to revolutionize patients' rights in the face of sex discrimination has recently been recognized for the first time in federal court.¹⁰¹ In March 2015, a district court in Minnesota refused to dismiss the claims of a trans patient who sued his local hospital for discrimination after suffering verbal insults, delays that put him at risk of sepsis, and unnecessary and invasive procedures at the hands of physicians and nurses at his local hospital.¹⁰²

Part III.A discusses Section 1557's expansive definition of sex discrimination and this definition's possible application to abortion, reproductive health information, and contraception. Using this definition of sex discrimination to ensure access to reproductive care does not necessarily entail infringement on conscience protections, as Part III.B shows. Rather, Section 1557 demonstrates a federal commitment to curtailing sex discrimination by ensuring access to care. This commitment should be understood as a counterweight to interests in religious liberty, thereby creating the need to balance these two interests. Section 1557 could therefore limit certain forms of refusals that have been authorized only on the state level and present meaningful barriers to access. Finally,

¹⁰¹. *Rumble v. Fairview Health Servs.*, No. 14-CV-2037, 2015 WL 1197415, at *1 (D. Minn. Mar. 16, 2015).

¹⁰². *Id.* at *3-7.

Part III.C develops an account of how Section 1557 should be interpreted as it applies to emergency reproductive care and information about health status in light of other federal and state statutes. Part III.C also addresses the way in which Section 1557 may interact with the Religious Freedom Restoration Act and why courts should analyze the ACA's nondiscrimination provision differently from the Supreme Court's analysis of the contraceptive mandate in *Hobby Lobby*.

A. *Section 1557's Expansive Definition of Sex Discrimination in Healthcare: Reproductive Access as Sex Equality Under the Law*

1. *Section 1557's Definition of Sex Discrimination*

The Affordable Care Act's non-discrimination provision provides patients with protection against a wide range of practices that newly constitute sex discrimination. Section 1557 of the ACA provides as follows:

[A]n individual shall not, on the ground prohibited under Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or section 794 of title 29, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments).¹⁰³

By covering all health programs and activities that "receiv[e] Federal financial assistance, including . . . contracts of insurance," the nondiscrimination provision reaches broadly to include hospitals and pharmacies, in addition to insurance providers.¹⁰⁴ Furthermore, the provision uses the definition of sex discrimination from Title IX, which includes discrimination on the basis of

¹⁰³. 42 U.S.C. § 18116 (2012) (internal citations omitted).

¹⁰⁴. *Id.* Section 1557 was held to apply to healthcare providers in *Rumble*, 2015 WL 1197415 at *12. It is well established that receipt of Medicare monies constitutes federal funding for the purposes of the reach of federal regulation. *See, e.g.*, *Grzan v. Charter Hosp. of N.W. Ind.*, 104 F.3d 116, 119-20 (7th Cir. 1997); *United States v. Baylor Univ. Med. Ctr.*, 736 F.2d 1039, 1046-49 (5th Cir. 1984). While this has most often applied in the context of hospitals, because pharmacies, too, receive federal funds in the form of Medicare monies, the same reasoning should apply.

pregnancy.¹⁰⁵ By specifically incorporating the “mechanisms provided for and available under . . . Title IX,” Section 1557 incorporates the private right of action for disparate treatment and disparate impact claims provided in Title IX.¹⁰⁶

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105. 20 U.S.C. § 168 (2012). The text of Title IX reads: “No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance.” *Id.* Regulations explain that the definition of sex discrimination includes discrimination on the basis of pregnancy. 34 C.F.R. 160.40(a) (2012) (“A recipient shall not discriminate against any student, or exclude any student from its education program or activity, including any class or extracurricular activity, on the basis of such student’s pregnancy, childbirth, false pregnancy, termination of pregnancy or recovery therefrom, unless the student requests voluntarily to participate in a separate portion of the program or activity of the recipient. . . . A recipient shall treat pregnancy, childbirth, false pregnancy, termination of pregnancy and recovery therefrom in the same manner and under the same policies as any other temporary disability with respect to any medical or hospital benefit, service, plan or policy which such recipient administers, operates, offers, or participates in with respect to students admitted to the recipient’s educational program or activity.”).
106. *Rumble*, 2015 WL 1197415, at *7 n.3, *11 (“Section 1557 provides Plaintiff with a private right of action to sue Defendants. The Court reaches this conclusion because the four civil rights statutes that are referenced and incorporated into Section 1557 permit private rights of action.” “[P]laintiffs bringing Section 1557 age, disability, or sex discrimination claims could allege disparate treatment or disparate impact.”). As held by the district court in *Rumble*, the first federal court to issue an opinion under Section 1557, by incorporating Title IX’s definition of sex discrimination as well as its private right of action, Section 1557 picks up its disparate impact claim. Under the bar on pregnancy and pregnancy-related discrimination in Title IX, the practices of Catholic hospital systems in following the Directives should constitute disparate treatment, but the ACA’s commitment to nondiscrimination extends to enable a disparate impact claim. It has been noted that Section 1557’s “anti-discrimination mandate is to be interpreted consistently with that of Title VI, Title IX, Section 504, and Age Discrimination Act, all of which have implemented regulations that prohibit both disparate impact, as well as intentional discrimination.” Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 HOW. L.J. 855, 872 (2012); see also *Nondiscrimination Protection in the Affordable Care Act: Section 1557*, NAT’L WOMEN’S L. CENTER (June 3, 2013), <http://www.nwlc.org/resource/nondiscrimination-protection-affordable-care-act-section-1557> [<http://perma.cc/T8UY-5U2E>].

While the focus in Part III is largely on the possibility of disparate treatment claims under Section 1557, a disparate impact claim may also be possible. The substance and structure of the argument would mirror the disparate treatment claims outlined in this Part. A disparate impact claim could capture the unique hardship faced by pregnant and pregnancy-capable women resulting from the Directives and overly expansive state laws. The claims would take as its relevant comparative groups men and women of reproductive age and consider the impact of hospital practices on each. The claims would demonstrate the particular burden suffered by women because of the policy not to provide miscarriage management or birth control coverage (the additional cost, time, anxiety about pregnancy, and potential effects of not being covered for contraceptives) as compared to men’s access to medically indicated services.

Through Section 1557, Congress recognized as sex discrimination, for the first time, certain practices relating to women's healthcare access. In addition to explicitly seeking to correct the practice of "gender rating," where insurers base premiums on the sex of the individual they are covering,¹⁰⁷ the history and text of the ACA demonstrate a commitment to sex nondiscrimination principles more broadly,¹⁰⁸ and Section 1557's specific reliance on Title IX's definition of sex discrimination suggests that the ACA aims to provide meaningful protections to women in healthcare. While regulations have not yet been promulgated, the Director of the Office of Civil Rights for the Department of Health and Human Services has emphasized, in an opinion letter, that Section 1557's ban on sex discrimination sweeps much more broadly than previous antidiscrimination law in this space.¹⁰⁹ It goes so far as to "extend[] to claims of discrimination based on gender identity or failure to conform to stereotypical notions of masculinity or femininity" and to prohibit "discrimination regardless of the actual or perceived sexual orientation or gender identity of the individuals involved."¹¹⁰ There is reason to believe, therefore, that Section 1557's nondiscrimination mandate should be read expansively.

2. *Protections Above the Equal Protection Clause: Section 1557 in the Context of Other Statutory Protections Against Pregnancy Discrimination*

Because the definition of sex discrimination incorporated into Section 1557 includes discrimination on the basis of pregnancy,¹¹¹ Section 1557 may be read

107. 42 U.S.C. § 300gg(a) (2012) (limiting discrimination in premium rates to a few categories not including sex). See 156 CONG. REC. H1873 (daily ed. March 21, 2010) (statement of Rep. Woolsey) ("I wonder how many of my colleagues realize that essentially being a woman is a preexisting condition."); see also Danielle Garrett, *Turning to Fairness: Insurance Discrimination Today and the Affordable Care Act*, NAT'L WOMEN'S L. CENTER 4 (Mar. 2012), http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf [<http://perma.cc/2CBE-3XEM>] (noting the difficulty of obtaining an individual market plan that includes maternity coverage).

108. 42 U.S.C. § 300gg-13 (2012) (establishing no additional cost-sharing requirements for additional preventative care and screenings needed "with respect to women"); Coverage of Preventive Health Services, 47 C.F.R. § 147.130(a)(iv) (2012); Health Res. & Servs. Admin., *Women's Preventive Services*, U.S. DEP'T HEALTH & HUMAN SERVICES (Aug. 1, 2011), <http://www.hrsa.gov/womensguidelines> [<http://perma.cc/JUK4-R9YZ>].

109. Letter from Leon Rodriguez, Dir. of Office for Civil Rights, Dep't of Health & Human Servs. to Maya Rupert, Fed. Pol'y Dir., Nat'l Ctr. for Lesbian Rights (July 12, 2012) (OCR Transaction No. 12-000800), <http://www.nachc.com/client/OCRLetterJuly2012.pdf> [<http://perma.cc/RB8V-ACZU>]; see also *Rumble*, 2015 WL 1197415, at *10.

110. Letter from Leon Rodriguez, *supra* note 109, at 1; see also *Rumble*, 2015 WL 1197415, at *10.

111. Section 1557 incorporates the definition of sex discrimination in Title IX, which in turn bars discrimination on the basis of pregnancy. Education Amendments of 1972, Pub. L. No. 92-

as a counterweight to expansive protections for religious liberty at the federal and state levels. Section 1557 provides antidiscrimination protections greater than those of the Equal Protection Clause by incorporating Title IX's definition. While Title IX's statutory text only defines impermissible discrimination as being "on the basis of sex," the regulations specifically ban discrimination against students, employees, and applicants on the basis of pregnancy.¹¹² By incorporating Title IX's definition of sex discrimination, Section 1557 therefore offers more robust protections than those guaranteed under the Constitution. For example, in *Geduldig v. Aiello*,¹¹³ the Supreme Court ruled that unfavorable treatment of pregnant women did not necessarily amount to sex discrimination in violation of the Equal Protection Clause.¹¹⁴ The Court held that where an insurance program excluded pregnant women from receiving benefits, the relevant categories were "pregnant women and nonpregnant persons."¹¹⁵ Such a program, the Court reasoned, was therefore not categorizing on the basis of sex and did not present an Equal Protection problem. But when the Court used the same logic to hold that Title VII's bar on sex discrimination in employment did

318, §§ 901-02, 86 Stat. 373, 374; 34 C.F.R. § 106.21(c)(2) (2012) (barring pregnancy discrimination in admissions); *Id.* at § 106.40(b) ("A recipient shall not discriminate against any student, or exclude any student from its education program or activity, including any class or extracurricular activity, on the basis of such student's pregnancy, childbirth, false pregnancy, termination of pregnancy or recovery therefrom, unless the student requests voluntarily to participate in a separate portion of the program or activity of the recipient."); *Id.* § 106.51(b)(6) (barring employment discrimination with respect to "[g]ranting and return from leaves of absence, leave for pregnancy, childbirth, false pregnancy, termination of pregnancy, leave for persons of either sex to care for children or dependents, or any other leave."); *Id.* § 106.57 (b) ("A recipient shall not discriminate against or exclude from employment any employee or applicant for employment on the basis of pregnancy, childbirth, false pregnancy, termination of pregnancy, or recovery therefrom."). See generally Off. for C.R., *Pregnant or Parenting? Title IX Protects You from Discrimination at School*, U.S. DEP'T EDUC. <http://www2.ed.gov/about/offices/list/ocr/docs/dcl-know-rights-201306-titleix.html> [<http://perma.cc/39WS-PB9Q>]; Letter from Leon Rodriguez, *supra* note 109.

112. See *supra* note 111.

113. 417 U.S. 484, 494 (1974).

114. While *Geduldig* held that classification on the basis of pregnancy did not amount to classification on the basis of sex, the Court opened some possibility of recognizing regulation of pregnant women as sex discrimination when that regulation rests on sex-role stereotypes. *Id.* In *Nevada Department of Human Resources v. Hibbs*, 538 U.S. 721 (2003), Justice Rehnquist, writing for the majority, found that judgments about mothers and future mothers constituted sex-role stereotypes and therefore constituted a violation of the Equal Protection Clause. For further discussion of how to read *Hibbs* and *Geduldig* in tandem, see Reva B. Siegel, *You've Come a Long Way, Baby: Rehnquist's New Approach to Pregnancy Discrimination in Hibbs*, 58 STAN. L. REV. 1871, 1891-94 (2006).

115. *Geduldig*, 417 U.S. at 497 n.20.

not reach pregnancy discrimination,¹¹⁶ Congress passed the Pregnancy Discrimination Act (PDA) to repudiate the Court's holding.¹¹⁷ This definition of sex discrimination, including pregnancy discrimination, is incorporated in Title IX and also in Section 1557.¹¹⁸

Section 1557 should therefore be understood to stand next to Title VII and Title IX, defining a statutory scheme of antidiscrimination law more robust than constitutional protections alone. Such a definition of sex discrimination provides more protections for women seeking healthcare, and specifically care related to reproduction.¹¹⁹ When providers single out a medical service specially affecting women's reproductive capacity for exclusion, they target pregnant women or women of childbearing age for unequal treatment.¹²⁰ When hospitals refuse pregnant women treatment or information because of their pregnancy, or refuse reproductive-age women treatment or information, the refusals are subject to scrutiny as sex discrimination under Section 1557.

Some might argue that if the ACA's nondiscrimination provision were intended to herald such a dramatic change in patients' rights, then it surely would have received more attention, especially amid high-profile challenges to the ACA, including *Hobby Lobby*¹²¹ and *King v. Burwell*.¹²² This argument, however, does not stand up to scrutiny. In fact, the House version of the provision would have created an even broader right, barring discrimination on *any*

116. *Gen. Elec. Co. v. Gilbert*, 429 U.S. 125 (1976).

117. Reva B. Siegel, *Employment Equality Under the Pregnancy Discrimination Act of 1978*, 94 *YALE L.J.* 929, 930 (1985).

118. *See supra* note 111.

119. Outside these enhanced statutory protections, scholars have made equality arguments for reproductive rights within a constitutional frame. *See* Reva B. Siegel, *Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression*, 56 *EMORY L.J.* 815, 821 (2007) ("The sex equality approach to reproductive rights opposes laws restricting abortion or contraception to the extent that such laws presuppose or entrench customary, gender-differentiated norms concerning sexual expression and parenting."); *see also* Jack M. Balkin, *How New Genetic Technologies Will Transform Roe v. Wade*, 56 *EMORY L.J.* 843, 857 (2007); David B. Cruz, "The Sexual Freedom Cases"? *Contraception, Abortion, Abstinence, and the Constitution*, 35 *HARV. C.R.-C.L. L. REV.* 299, 302 (2000).

120. The legislative history of the Women's Health Amendment of the ACA acknowledges the particular need to protect women's access to reproductive health as a matter of sex equality. "Researchers have shown that access to contraception improves the social and economic status of women," and contraceptive access "further the goal of eliminating [gender] disparit[ies] by allowing women to achieve equal status as healthy and productive members" of society. 77 *Fed. Reg.* 8725, 8728 (Feb. 15, 2012).

121. 134 S. Ct. 2751 (2014).

122. No. 14-114 (U.S. argued Mar. 4, 2015) (No. 14-114) (challenging the provision of federal subsidies to low-income individuals enrolled on federal, rather than state, exchanges).

ground apart from the “need for medical care.”¹²³ The version of Section 1557 that is law today therefore represents a more modest articulation of the rights Congress contemplated. Taken together, the House and Senate versions demonstrate an intention to create a robust antidiscrimination right for patients.¹²⁴ Such a commitment to nondiscrimination is, perhaps, unsurprising in the context of a law that aimed to expand access to healthcare to all Americans.

Beyond the record of the various versions of the nondiscrimination provision, there is relatively little legislative history on Section 1557. Again, however, Congress’s silence does not necessarily suggest it did not mean Section 1557 to significantly alter patients’ rights. Rather, the lack of history may indicate that the provision made its way quietly into the ACA in order to avoid attention and conflict. This path would mirror that of the contraception mandate, which was incorporated with little fanfare through circuitous administrative policy-setting.¹²⁵

123. Watson, *supra* note 106, at 872.

124. The lack of legislative history on the provision may be explained by a desire of the drafters to create potentially broad antidiscrimination rights while avoiding extensive debate about the controversial aspects of the law. Given the peculiar history of the ACA’s passage, see, for example, John Cannan, *A Legislative History of the Affordable Care Act: How Legislative Procedure Shapes Legislative History*, 105 LAW LIBR. J. 131 (2013) and Abbe Gluck, *How Congress Works (And the ObamaCare Subsidies Lawsuit)*, BALKINIZATION (Dec. 12, 2013, 9:59 AM), <http://balkin.blogspot.com/2013/12/how-congress-works-and-obamacare.html> [<http://perma.cc/72HG-GJXF>] (discussing the factual circumstances that led to the failure to reconcile the House and Senate versions of the ACA), such a result may not be entirely surprising.

125. The Women’s Health Amendment, which ultimately became the source of the contraceptive mandate, stipulated that the Health Resources and Services Administration (“HRSA”) would determine, in future findings, which preventive health services to include. 42 U.S.C. § 300gg-13(a)(4) (2012). Discussions of the amendment in the legislative history focused on correcting “punitive insurance company practices that treat simply being a woman as a pre-existing condition,” and the debate paid particular attention to the provision of early detection screenings for cancers, specifically mammograms. Press Release, Senate Approves Mikulski Amendment Making Women’s Preventive Care Affordable and Accessible (Dec. 3, 2009), <http://www.mikulski.senate.gov/media/enewsletter/December-2009-Womens-Health-Amendment.cfm>. [<http://perma.cc/7TMB-L36E>].

There was nevertheless some acknowledgment that HRSA guidelines would include “family planning” (never defined to include contraception explicitly) among other services. See, e.g., 155 CONG. REC. S12027 (daily ed. Dec. 1, 2009) (statement of Sen. Gillibrand) (stating the amendment would incorporate “more preventive screening . . . including for postpartum depression, domestic violence, and family planning.”); 155 CONG. REC. S12114 (daily ed. Dec. 2, 2009) (statement of Sen. Feinstein) (stating the amendment “will require insurance plans to cover at no cost basic preventive services and screenings for women. This may include mammograms, Pap smears, family planning, screenings to detect postpartum depression, and other annual women’s health screenings”).

Furthermore, the legislative history on the ACA's interaction with conscience protections suggests that Congress intended to create rights to healthcare that might well realign the current balance between access to care and rights of religious refusal. Indirect evidence of congressional intent may be found in discussions of abortion and conscience protection under the ACA as a whole. The Women's Health Amendment¹²⁶ (which ultimately brought about the contraception mandate) arguably exemplifies the balance between healthcare access and conscience protection that Congress struck in the ACA. Strong conscience protections that would have crippled the Act's nondiscrimination provision were proposed and summarily rejected.¹²⁷

In fact, that the ACA might curtail broad medical refusal laws was recognized by some key players during floor debate. The USCCB authored a letter, read out on the Senate floor, that opposed the ACA's potential reach to abortion services; the USCCB thereby acknowledged the ACA's potential effects on religious refusals and the Bishops' own Directives.¹²⁸ Similar objections to the ACA's treatment of abortion were raised by Republican Senators during floor debate and were not given effect in the bill's final version.¹²⁹ Additionally, Congress explicitly rejected expanding the federal conscience clause or providing for explicit conscience protection in the ACA when it voted down the Brownback Amendment, which would have prevented the ACA from "requir[ing] an individual or institutional health care provider to provide, participate in, or refer for an item or service to which such provider has a moral or religious objection, or require such conduct as a condition of contracting with a qualified health plan."¹³⁰ Moreover, while the ACA does not change federal

The subsequent HRSA guidelines are based in part on a study HRSA commissioned from the Institute of Medicine (IOM). The IOM is part of the National Academy of Sciences, a "semi-private" organization Congress established "for the explicit purpose of furnishing advice to the Government." *Pub. Citizen v. Dep't of Justice*, 491 U.S. 440, 460 n.11 (1989). They include preventive screenings discussed in the adoption of the amendment but also require coverage of "[a]ll Food and Drug Administration [(FDA)] approved contraceptive methods . . . and patient education and counseling for all women with reproductive capacity." *Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act*, 77 Fed. Reg. 8725 (Feb. 15, 2012).

126. 42 U.S.C. § 300gg-13(a)(4) (2012).

127. *See, e.g.*, 155 CONG. REC. S13193-01 (daily ed. Dec. 14, 2009).

128. 155 CONG. REC. S11929 (daily ed. Nov. 21, 2009).

129. *E.g.*, 155 CONG. REC. S11926 (daily ed. Nov. 21, 2009) (statement of Sen. Hatch) (arguing the ACA "has stronger protections for abortion providers than for providers who have conscience objections to abortion.").

130. 155 CONG. REC. S13193-01 (2009).

conscience protection,¹³¹ the Act makes clear that it could restrict state-level conscience protection, indicating that Congress expected the ACA to ban some practices authorized under state law at the time.¹³²

3. *Expanding the Theory of Pregnancy Discrimination as Sex Discrimination To Reach Reproductive Care Under Section 1557*

Section 1557's expansive definition of sex discrimination potentially affects medical refusals that deny women reproductive care. Equality arguments for reproductive care flow from the differential treatment of pregnant or pregnancy-capable women, who are denied a category of care. This argument rests on the incorporation of pregnancy discrimination as sex discrimination in the statute by reference to Title IX. When Title IX's prohibition on pregnancy discrimination has been tested in courts, the litigation has primarily pertained to pregnant high school students who were denied admission to the National Honor Society (NHS).¹³³ But these cases have clearly reaffirmed Title IX's reach, recognizing pregnancy discrimination as sex discrimination under the law.

By expanding the definition of sex discrimination to include pregnancy discrimination, Section 1557 calls into question a broad set of exclusions, including the denial of contraception and abortion. In the context of access to contraception, for example, singling out contraceptives for exclusion may constitute sex discrimination under Section 1557 via its incorporation of Title IX and close relationship to Title VII.¹³⁴ Under Title VII, the Pregnancy Discrimination Amendment (PDA) has been understood to reach contraceptive coverage.¹³⁵

131. 42 U.S.C. § 18023(c)(2)(a)(i) (2012) (“Nothing in this Act shall be construed to have any effect on Federal laws regarding . . . conscience protection.”).

132. *Id.* § 18023(c)(1)-(2) (stating that the ACA shall not “preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor” but omitting “conscience protection,” which is enumerated among the areas of federal law that should be unencumbered by the ACA).

133. *See, e.g.,* Ollier v. Sweetwater Union High Sch. Dist., 604 F. Supp. 2d 1264 (S.D. Cal. 2009); Chipman v. Grant Cnty. Sch. Dist., 30 F. Supp. 2d 975 (E.D. Ky. 1998). In those cases, pregnancy discrimination was recognized in federal courts as actionable under Title IX.

134. *See, e.g.,* Kathleen A. Bergin, *Contraceptive Coverage Under Student Health Insurance Plans: Title IX as a Remedy for Sex Discrimination*, 54 U. MIAMI L. REV. 157 (2000) (arguing that Title IX's definition of sex discrimination could be used to prevent universities from excluding contraceptive coverage from student health plans).

135. Plaintiffs—such as Hobby Lobby's or Conestoga Wood's employees—could challenge their employers' singling out of contraception for exclusion from employee health plans as sex discrimination under Title VII. In this respect, the right of action outlined above related to

(This definition of sex discrimination under Title VII was not at issue in *Hobby Lobby*, and therefore the Court did not address it.¹³⁶) Further, the EEOC has interpreted Title VII's definition of sex discrimination to forbid singling out contraception for exclusion.¹³⁷ This reading has also been endorsed by several federal courts¹³⁸ but rejected by others.¹³⁹ However, the EEOC reaffirmed this reading of Title VII in guidance issued after the *Hobby Lobby* decision—demonstrating a belief that *Hobby Lobby* did not alter the meaning of sex discrimination under Title VII.¹⁴⁰ The idea that contraceptive access as an equality concern is also found outside the Title VII context in state contraceptive equity laws,¹⁴¹ and even in some of the arguments aired to the Supreme Court in *Griswold v. Connecticut*¹⁴²—the first articulation of a constitutional right to contraception.¹⁴³

contraceptive care could be marshaled, in a way parallel to Title VII, to combat the Court's ruling in *Hobby Lobby*.

136. Some scholars have argued that the Court's analysis of the contraceptive mandate in *Hobby Lobby* left room for a more robust account of the "compelling interest" at stake in contraceptive coverage. Neil S. Siegel & Reva B. Siegel, *Compelling Interests and Contraceptive Coverage*, 47 CONN. L. REV. 1025 (2015). Section 1557 may be understood as an articulation by Congress of a clear compelling interest in ensuring access to reproductive services and information.
137. See, e.g., *Enforcement Guidance: Pregnancy Discrimination and Related Issue*, Equal Emp. Opportunity Commission (July 14, 2014), http://www.eeoc.gov/laws/guidance/pregnancy_guidance.cfm [<http://perma.cc/U68E-3Q8V>] ("[E]mployment decisions based on a female employee's use of contraceptives may constitute unlawful discrimination based on gender and/or pregnancy. Contraception is a means by which a woman can control her capacity to become pregnant, and, therefore, Title VII's prohibition of discrimination based on potential pregnancy necessarily includes a prohibition on discrimination related to a woman's use of contraceptives.").
138. See *Cooley v. Daimler Chrysler Corp.*, 281 F. Supp. 2d 979, 984-85 (E.D. Mo. 2003); *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1273-74 (W.D. Wash. 2001).
139. See e.g., *In re Union Pac. R.R. Emp't Practices Litig.*, 479 F.3d 936, 955-45 (8th Cir. 2007).
140. *Enforcement Guidance: Pregnancy Discrimination and Related Issues*, *supra* note 137.
141. Twenty-eight states currently have contraceptive equity laws. *State Policies in Brief: Insurance Coverage of Contraceptives*, GUTTMACHER INST., http://www.guttmacher.org/statecenter/spibs/spib_ICC.pdf [<http://perma.cc/4CWY-8XQ4>]; see also Cornelia T.L. Pillard, *Our Other Reproductive Choices: Equality in Sex Education, Contraceptive Access, and Work-Family Policy*, 56 EMORY L.J. 941, 967 (2006) (discussing how state contraceptive equity laws "reinforc[e] and expand[] on the PDA's approach" to contraceptive access as an equality concern).
142. 381 U.S. 479 (1965).
143. Sex equality arguments for contraception surfaced in *Griswold*, even though the Court had not, in 1965 when it decided *Griswold*, ever invalidated a law on the grounds of sex discrimination under the Equal Protection Clause. (The Court first recognized sex discrimination claims under the Equal Protection Clause six years later in *Reed v. Reed*, 404 U.S. 71 (1971).) Nevertheless, the arguments raising equality concerns were present when the Court heard

These same arguments extend to abortion, an area that also potentially raises concerns of pregnancy discrimination.¹⁴⁴ Even under the less robust constitutional regime of sex discrimination protection, scholars have argued for recognizing equality interests at the heart of the constitutional abortion right.¹⁴⁵ The extension of sex discrimination to abortion under Title VII and Title IX, however, has been less tested than the contraceptive access question. It also remains more uncertain because Title IX is explicitly neutral on abortion and does not require any entity to provide or pay for abortion care.

In the context of information relating to reproductive health, the underlying equality interest is the same. If medical information is withheld, pregnant or pregnancy-capable women are uniquely denied access to critical information.

B. Balancing Sex Equality Concerns and Religious Liberty

Using Section 1557 to increase access to information and care would not necessarily restrict the central federal rights that conscience clauses have historically aimed to protect. Section 1557 should be understood as a congressional commitment to ensuring statutory rights to reproductive care. This federal commitment will, of course, clash with other federal and state conscience protections. But courts can strike a balance between equality interests and religious

Griswold. See Neil S. Siegel & Reva B. Siegel, *Contraception as a Sex Equality Right*, 124 YALE L.J. F. 349 (2015), <http://www.yalelawjournal.org/forum/contraception-as-a-sex-equality-right> [<http://perma.cc/ZML6-QN3Y>]. For example, the ACLU's amicus brief used the Nineteenth Amendment to ground its equality argument:

In addition to its economic consequences, the ability to regulate child-bearing has been a significant factor in the emancipation of married women. In this respect, effective means of contraception rank equally with the Nineteenth Amendment in enhancing the opportunities of women who wish to work in industry, business, the arts, and the professions. Thus, the equal protection clause protects the class of women who wish to delay or regulate child-bearing effectively.

Brief for the American Civil Liberties Union and the Connecticut Civil Liberties Union as Amici Curiae Supporting Petitioner, *Griswold v. Connecticut*, 381 U.S. 479 (1965) 15-16 (internal citations omitted). In fact, Justice Brennan asked during the *Griswold* oral arguments: “[W]ouldn’t you have had a rather compelling equal protection argument?” Transcript of Oral Argument at 4, *Griswold v. Connecticut*, 381 U.S. 479 (No. 496), http://www.oyez.org/cases/1960-1969/1964/1964_496 [<http://perma.cc/B53T-TQ86>].

144. See, e.g., Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955, 978, 981 (1984).

145. See Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to Roe v. Wade*, 63 N.C. L. REV. 375 (1985); Neil S. Siegel & Reva B. Siegel, *Equality Arguments for Abortion Rights*, 60 UCLA L. REV. DISCOURSE 160 (2013), <http://www.uclalawreview.org/?p=4186> [<http://perma.cc/6XYM-Y2J8>].

liberty that respects conscience claims while keeping in view the potential harms to patients.¹⁴⁶

Catholic hospitals and providers might draw on RFRA, a “permissive accommodation of [the free exercise of] religion,”¹⁴⁷ as the primary source of statutory protection against infringements on religious liberty. In RFRA, Congress provided additional protection for the practice of religion—above the constitutional requirements imposed by the Free Exercise Clause—as long as RFRA’s application does not compromise compelling interests served by other federal laws.¹⁴⁸ Under this framework, Section 1557’s commitments to healthcare access may represent a compelling interest upon which conscience-based medical refusals may infringe. Under the ACA, the federal government’s interest in assuring access to care presents a compelling antidiscrimination mandate that should be taken seriously by courts.

This kind of balancing analysis mirrors the way in which burden-shifting typically works in antidiscrimination law.¹⁴⁹ Demonstrating that a formal policy constitutes facial sex discrimination would be only the first step in establishing liability under Section 1557. Section 1557, by incorporating Title IX, dictates that when healthcare providers have created an unlawful classification based on sex, a strong presumption is created that the challenged policy violates the law.¹⁵⁰ Once such a policy is established, the healthcare provider would have to articulate a permissible justification for the sex-based classification.¹⁵¹ In the context of religious or religiously affiliated healthcare providers, hospitals op-

146. NeJaime and Siegel call attention to the “third-party harms” that flow from medical refusals laws that have followed in the wake of the Church Amendment. NeJaime & Seigel, *supra* note 43.

147. Siegel & Siegel, *supra* note 136, at 2.

148. *Id.*

149. The burden-shifting model was introduced by the Supreme Court in *McDonnell Douglas v. Green*, 411 U.S. 792 (1973) and reaffirmed in *Texas Department of Community Affairs v. Burdine*, 450 U.S. 248 (1981). It has become standard analysis in adjudicating Title VII disparate treatment claims. See, e.g., Tristin K. Green, *Making Sense of the McDonnell Douglas Framework: Circumstantial Evidence and Proof of Disparate Treatment under Title VII*, 87 CALIF. L. REV. 983 (1999).

150. For example, in *City of Los Angeles, Dep’t of Water & Power v. Manhart*, 435 U.S. 702 (1978), the Supreme Court held, in a Title VII case, that a policy that required female employees to make larger contributions to a pension fund than male employees created an unlawful classification based on sex. Title IX incorporates this same approach to policies that classify on the basis of sex. *Title IX Legal Manual*, U.S. DEP’T JUST., <http://www.justice.gov/crt/about/cor/coord/ixlegal.php> [<http://perma.cc/3M53-J6BK>] (“It is generally accepted . . . that the substantive standards and policies developed under Title VII apply with equal force . . . under Title IX.”).

151. This same requirement applies in a “pattern or practice” of individual disparate treatment action. See, e.g., *Teamsters v. United States*, 431 U.S. 324, 360-62 (1977).

erating under the Directives would surely assert that the nondiscriminatory reason for their exclusions on care is conscientious or religious objection. But the challenge would not end there. Even when a lawful justification for the challenged policy can be articulated, Section 1557, by incorporating Title IX's definition of sex discrimination, seems to require tailoring for a policy challenged as disparate treatment in order to minimize the resulting discrimination, even if such a policy has benign motivations.¹⁵² The analogy to Title VII burden-shifting would suggest that even where healthcare providers justify limits on care on the basis of religious belief, the nondiscrimination mandate requires the challenged policy to minimize the resulting discrimination.

This balancing test involves analyzing both the protections for conscience claimants and the interests of patients seeking services. As Part I of this Note demonstrates, central federal conscience protections for healthcare providers, properly understood—in the Church Amendment¹⁵³ and other federal law¹⁵⁴—historically protect the individual provider (doctor or nurse) who does not want to directly perform or assist in performing an abortion.¹⁵⁵ This notion is consistent with the way many people intuitively understand the balance of rights at stake in medical refusals. Particularly where a woman's life and well being hang in the balance, claims of conscience that lie at the level of an institu-

152. For example, in the context of a policy that requires criminal background checks that may run afoul of the Title VII bar on disparate treatment or disparate impact and the narrow tailoring requirement, EEOC enforcement guidance mandates stringent narrow tailoring. *Consideration of Arrest and Conviction Records in Employment Decisions Under Title VII of the Civil Rights Act of 1964*, EEOC Enforcement Guidance No. 915.002 (Apr. 25, 2012), http://www.eeoc.gov/laws/guidance/arrest_conviction.cfm [<http://perma.cc/C296-C7C2>] (“Depending on the facts and circumstances, an employer may be able to justify a targeted criminal records screen Such a screen would need to be narrowly tailored to identify criminal conduct with a demonstrably tight nexus to the position in question.”).

153. The legislative history of the Church Amendment (to the Public Health Service Act) supports this focus on protecting individual providers, making clear that the conscience protections would not apply to a hospital employee “who had no responsibility, directly or indirectly, with regard to the performance of [the] procedure.” 119 CONG. REC. S9597 (1973) (statement of Sen. Long). For a discussion of the significance of this legislative history, see NeJaime & Siegel, *supra* note 43.

154. Conscience claims by providers recognized at the federal level do not cover institutional or individual objection to providing information or contraception. *See supra* Part I.B.

155. Scholars have argued compellingly that the core of the conscience right is at the individual level, particularly where we weigh those conscience claims against significant harms that might flow to other individuals as a result of the exemption sought. *See, e.g.*, Elizabeth Sepper, *Taking Conscience Seriously*, 98 VA. L. REV. 1501, 1528, 1553 (2012) (“[C]oncern for the individual's moral integrity has been at the heart of the debates over conscience in medicine.”) (tracking the philosophical history of conscience and concluding that a system “that treats individual and institutional conscience as equal to one another” is untenable given this history).

tional policy rather than an individual's objection to performing an abortion should not be permitted to trump the patient's rights.¹⁵⁶

As Part II of this Note has demonstrated, M&A activity between hospitals increasingly brings nonsectarian hospitals into the widening circle of providers that deny women medically necessary reproductive care and health information. The reach of medical refusals will likely increase further among nonsectarian hospitals given the trend in hospital consolidation. As more historically nonsectarian hospitals come under the Directives' control, a dwindling percentage of medical refusals will involve either the central claim of an individual physician refusing to participate directly in an abortion or even an objection raised by a historically religious hospital. Today, even attenuated commercial relationships between religious and nonsectarian healthcare providers have caused nonsectarian providers to cease offering a full range of reproductive care.¹⁵⁷ That the Directives now reach nonsectarian institutions that may hold no meaningful religious affiliation beyond commercial relationships demonstrates how much Section 1557 could do to increase reproductive health access and patients' rights without compromising core religious rights of objectors.¹⁵⁸

Rather than challenging conscience protections of individual healthcare providers, Section 1557 constrains institutional claims of conscience and frees up willing physicians employed at religious hospitals to provide services. In this sense, Section 1557 may liberate physicians currently employed at religious and religiously affiliated hospitals to care for their patients.¹⁵⁹ For example, Dr.

156. The Supreme Court's recent decision in *Hobby Lobby*, which recognized some corporations' religious objections to contraceptive coverage, may appear to present a challenge to this logic about the significance of conscience claims that have not been as historically present as an individual healthcare provider objecting to providing abortion. However, as Part III.C, *infra*, explains, the Court's concern for the offset of third-party harms distinguishes medical refusals, particularly in the emergency context, from contraceptive coverage. This is particularly true given that in *Hobby Lobby*, the Government had established an alternative means of providing coverage to women employed at religious non-profits that, the Court claimed, could be extended. Therefore, to the extent that *Hobby Lobby* can be read to expand our conception of conscience claims under RFRA, the Court has authorized such claims only when they do not lead to harms to third parties. For further discussion of this distinction, see NeJaime & Siegel, *supra* note 43.

157. See Jill Cowan, *Hoag Hospital Can Refuse Elective Abortions, State Rules*, L.A. TIMES, Apr. 4, 2014, <http://www.latimes.com/local/lanow/la-me-ln-hoag-abortions-20140404-story.html> [<http://perma.cc/YGG9-73X6>].

158. See Sepper, *supra* note 155, at 1545 (stating that "[t]he notion that an institutional position represents the collective morality, which is central to the moral-collective theory, swiftly falls apart as organizations become larger and less cohesive" in the context of contemporary M&A activity).

159. Some physicians currently employed at religious hospitals may feel it is their moral obligation to perform medically necessary reproductive services but may currently be prevented

Brian Smits, an ob/gyn working at a Catholic hospital, faced such a dilemma when a patient, whose membranes had ruptured, needed an induced abortion. Dr. Smits reflected:

I'm on call when she gets septic, and she's septic to the point that I'm [using medication] to keep her blood pressure up and I have her on a cooling blanket because she's 106 degrees. And I needed to get everything out [of the uterus]. And so I put the ultrasound machine on and there was still a heartbeat, and [the hospital ethics committee] wouldn't let me [do the procedure] because there was still a heartbeat. And this woman is dying before our eyes.¹⁶⁰

Dr. Smits felt obligated to induce the abortion—"I was just livid"—but the claims of institutional conscience trumped both his own desire to perform the necessary medical procedure and also the rights of the patient dying on the table.¹⁶¹ Stories like that of Dr. Smits illustrate the potential to offer comprehensive reproductive care at religiously affiliated hospitals without compromising the religious convictions of individual providers. Such reforms might well, in fact, respond to the conscience claims of doctors and nurses who feel it is their duty to assist patients in such situations.

C. Section 1557 in Light of Other Federal and State Laws

To be sure, Section 1557's commitments to equality in access to care may conflict with protections for the religious liberty of healthcare institutions and providers. The appropriate balance between these interests may differ depending on whether the care and counseling sought is emergency or non-emergency. This Note considers the application to emergency abortion care and access to information about health status. It argues that when denial of emergency reproductive services constitutes sex discrimination, there may be limits to the permissive accommodations for religious refusals, including those under RFRA. Section 1557 may reach beyond these applications, but this Part illustrates one way in which the ACA's nondiscrimination provision advances core rights of female patients.

from doing so by their employer. Lori Freedman has chronicled the plight of these physicians. See generally LORI FREEDMAN, WILLING AND UNABLE (2010).

160. *Id.* at 121.

161. *Id.*

1. *Section 1557 in Light of RFRA*

RFRA's green light for medical refusals now comes up against the nondiscrimination interests vindicated by Section 1557's emergency care mandate. As explained above, RFRA is properly understood as a permissive accommodation for religious exercise. It constrains generally applicable laws that substantially burden religious practice, but only insofar as the accommodation does not infringe on another compelling interest. Section 1557 vindicates the government's interest in sex equality in healthcare, and the provision therefore may reel in the permissive religious accommodation conferred under RFRA.

Resolving the competing interests in this federal statutory conflict would require a two-step analysis. When the Government has substantially burdened an entity's exercise of religion, that entity gains a RFRA exemption unless the government "demonstrates that application of the burden to the person – (1) is in furtherance of a compelling government interest; and (2) is the least restrictive means of furthering that compelling government interest."¹⁶² This test is the same one that the Supreme Court applied in *Hobby Lobby* when it sustained a RFRA challenge to the ACA's contraceptive mandate. Were a court to consider this test in the context of Section 1557, however, the result would likely be different because of both the *specific* compelling government interest at stake and the third party harms that flow from medical refusals to provide emergency care.

As to the first prong, Section 1557 invokes a stronger compelling interest than the one advanced by the government in *Hobby Lobby*. In *Hobby Lobby*, the Government argued that its primary interests at stake were promoting "public health" and "gender equality."¹⁶³ The majority criticized these interests as overly "broad."¹⁶⁴ One might disagree with the Court on how "broad" gender

162. 42 U.S.C. § 2000bb-1(b) (2012). The text of RFRA states:

(a) In general[:] Government shall not substantially burden a person's exercise of religion even if the burden results from a rule of general applicability, except as provided in subsection (b) of this section.

(b) Exception[:] Government may substantially burden a person's exercise of religion only if it demonstrates that application of the burden to the person –

(1) is in furtherance of a compelling governmental interest; and

(2) is the least restrictive means of furthering that compelling governmental interest.

163. *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2779 (2014).

164. The Court stated that RFRA requires courts to "scrutiniz[e] the asserted harm of granting *specific* exemptions to *particular* religious claimants" beyond stating interests broadly. *Id.* (quoting *Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal*, 546 U.S. 418, 431 (2006)) (emphasis added).

equality interests really are; however, it is clear that the general interest in promoting gender equality is not equivalent to the *specific* interest of enforcing a particular federal statute that defines the religious exemption sought as sex discrimination. Because Congress in the ACA has statutorily defined the practice in question as sex discrimination, the Government's interest is substantiated and specific: enforcing a federal antidiscrimination protection.

In fact, in *Hobby Lobby*, the Court acknowledged RFRA's limits on occasions when the law confronts antidiscrimination protections. The majority strenuously insisted that its decision provided "no . . . shield" for allowing "discrimination in hiring, for example on the basis of race, [that] might be cloaked as a religious practice to escape legal sanction. . . . The Government has a compelling interest in providing an equal opportunity to participate in the workforce without regard to race, and prohibitions on racial discrimination are precisely tailored to achieve that critical goal."¹⁶⁵ The Court made such an effort to distinguish the situation in *Hobby Lobby* from that arising in religious challenges to antidiscrimination law because, in general, religious objection claims have failed in the face of racial discrimination claims.¹⁶⁶ The specific focus on race in this passage from *Hobby Lobby* should not be read to exclude other forms of discrimination from consideration; the majority presents race as an "example."¹⁶⁷

Importantly, religious objections have failed in the face of sex discrimination claims before. For example, in *Dole v. Shenandoah Baptist Church*, the Fourth Circuit applied Title VII and rejected the argument that religious schools should be able to pay women less than men based on the belief that the "Bible clearly teaches that the husband is the head of the house, head of the

^{165.} *Hobby Lobby*, 134 S. Ct. at 2783.

^{166.} See, e.g., *Newman v. Piggie Park Enters., Inc.*, 256 F. Supp. 941 (D.S.C. 1966), *aff'd in relevant part and rev'd in part on other grounds*, 377 F.2d 433 (4th Cir. 1967), *aff'd and modified on other grounds*, 390 U.S. 400 (1968) (holding that while the owner of a barbecue chain "has a constitutional right to espouse the religious beliefs of his own choosing, however, he does not have the absolute right to exercise and practice such beliefs in utter disregard of the clear constitutional rights of other citizens. This court refuses to lend credence or support to his position that he has a constitutional right to refuse to serve members of the Negro race in his business establishments upon the ground that to do so would violate his sacred religious beliefs.").

^{167.} *Hobby Lobby*, 134 S. Ct. at 2783. While race arguably occupies a special place in American equal protection and antidiscrimination jurisprudence, this special status does not mean that race is completely unique and should be considered different in kind from other forms of discrimination. Other forms of discrimination, including sex discrimination, are often analogized to race discrimination. So the point that the Court explicitly used race as an "example" here suggests that the majority did not mean to speak only to race to the exclusion of other forms of discrimination.

wife, head of the family.”¹⁶⁸ The court stated that the government interest in preventing affirmative discrimination was of the “highest order.”¹⁶⁹ The Ninth Circuit similarly rejected a religious school’s argument that it should be allowed to offer unequal benefits to men and women.¹⁷⁰

RFRA challenges to Title VII’s bar on discrimination have succeeded only in extremely narrow circumstances.¹⁷¹ They have for the most part prevailed only when the claim for religious exemption mirrors the traditional common law “ministerial exemption,” which involves the right of religious institutions to teach the precepts of theology in accordance with their religion.¹⁷² Therefore, if a court did not weigh heavily the compelling interest in preventing sex discrimination, it would be dramatically revising the existing jurisprudence on the relationship between RFRA and federal antidiscrimination law.

For the second prong of RFRA analysis, the “least restrictive means” test, Section 1557 would entail a different calculus than the Court applied in *Hobby Lobby*, though the extent of that difference depends on context. In *Hobby Lobby*,

¹⁶⁸. 899 F.2d 1389, 1392 (4th Cir. 1990).

¹⁶⁹. *Id.* at 1398 (quoting *Wisconsin v. Yoder*, 406 U.S. 205, 214 (1972)).

¹⁷⁰. *EEOC v. Fremont Christian Sch.*, 781 F.2d 1362 (9th Cir. 1986). In *EEOC v. Tree of Life Christian Schs.*, 751 F. Supp. 700 (S.D. Ohio 1990), the court reasoned along the same lines. *See also* *Hamilton v. Southland Christian Sch. Inc.*, 680 F.3d 1316, 1320 (11th Cir. 2012) (rejecting a claim by a religious school that it should be allowed to fire a teacher for becoming pregnant outside of marriage); *Ganzy v. Allen Christian Sch.*, 995 F. Supp. 340, 350 (E.D.N.Y. 1998) (finding that a religious school could not discriminate on the basis of pregnancy because of its objection to sex outside marriage); *Vigars v. Valley Christian Ctr.*, 805 F. Supp. 802, 808-10 (N.D. Cal. 1992) (denying a free exercise challenge to Title VII by a religious school who fired an employee who became pregnant outside of marriage). While Title VII is generally applicable to religious institutions, there is currently a conflict regarding the proper test to apply to Title VII’s narrow co-religionist exemption. *See* Roger W. Dyer, Jr., *Qualifying for the Title VII Religious Organization Exemption: Federal Circuits Split over Proper Test*, 76 MO. L. REV. 545, 546 n.10 (2011). The exemption allows institutions whose “purpose and character are primarily religious,” *EEOC v. Townley Eng’g & Mfg. Co.*, 859 F.2d 610, 618 (9th Cir. 1988), to prefer co-religionists in hiring and other employment decisions. *See* Section 702 of Title VII, 42 U.S.C. § 2000e-1(a). However, the question of how far the Title VII exemption reaches is separate from courts’ consideration of the general applicability of Title VII nondiscrimination requirements to religious employers.

¹⁷¹. *E.g.*, *Gen. Conference Corp. of Seventh-Day Adventists v. McGill*, 617 F.3d 402, 409 (6th Cir. 2010); *Tomic v. Catholic Diocese of Peoria*, 442 F.3d 1036, 1038 (7th Cir. 2006).

¹⁷². *See, e.g.*, *Tomic*, 442 F.3d at 1038 (holding that a former music director and organist at a church could not bring an ADEA claim when he was replaced with a young person due to the common law ministerial exemption); *EEOC v. Catholic Univ. of Am.*, 83 F.3d 455, 468-69 (D.C. Cir. 1996) (barring a Title VII claim by a nun who alleged sex discrimination and stating that “the Government’s interest in eliminating employment discrimination is insufficient to overcome a religious institution’s interest in being able to employ the ministers of its choice” per the ministerial exemption).

when the Supreme Court analyzed the burden faced by women whose employers would refuse to provide contraceptive coverage, it relied largely on the unique factual circumstance that “HHS ha[d] already established an accommodation for nonprofit organizations with religious objections” to providing the coverage.¹⁷³ These points allowed the Court to conclude that the effect on women of a religious exemption would be “precisely zero.”¹⁷⁴ Justice Kennedy’s concurrence particularly emphasized that the Court would not implicate third-party harms because “the mechanism for [accommodation] [wa]s already in place” to ensure that women would not be denied coverage.¹⁷⁵

The Court’s—and Justice Kennedy’s—concern about the offset of harm to women indicates that for at least five of the Justices, the “least restrictive means” analysis under RFRA may well come out differently when considering the provision of emergency, life- or health-preserving services, and health status information. Because Section 1557 reaches the provision of services and information by healthcare providers, a court could not readily claim “zero” impact in the context of emergency healthcare or where women are denied the very information about necessary treatment that they may not know or be reasonably able to seek elsewhere. This is especially true where Catholic or religiously affiliated hospitals are the sole community providers. Increasingly, Catholic hospitals are the sole or primary providers: as of 2011, there were thirty Catholic hospitals serving as sole community providers.¹⁷⁶ These hospitals see over 890,000 emergency room visits annually.¹⁷⁷

2. *Access to Information about Health Status in Light of Other Federal and State Laws*

Section 1557 should be understood to establish that nondiscrimination in healthcare requires pregnant women to have access to the same level of information about their conditions as any non-pregnant patient. While Section 1557 does not create an explicit, affirmative duty to provide reproductive information to patients, it prohibits healthcare providers from deciding whether to disclose or withhold information to patients on a discriminatory basis. Providers’ practice of providing all relevant information in other cases would there-

173. *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2782 (2014).

174. *Id.* at 2760.

175. *Id.* at 2786 (Kennedy, J., concurring). However, as of this writing, it is unclear when or exactly how employees of Hobby Lobby and other for-profit entities with religious or moral objection to providing contraceptive coverage will regain coverage.

176. Uttley et al., *supra* note 94, at 25.

177. *Id.*

fore render discriminatory the choice not to provide information to pregnant patients under Section 1557.

Under Section 1557, the hospital would have to inform a patient like Tamesha Means that she might need to seek an abortion in the future, even if the hospital would not perform it. In the context of hospital consolidation—where Catholic or religiously affiliated hospitals increasingly serve as sole community providers—solving the problem of information alone may not solve the access problem. Nevertheless, scaling back conscience clause accommodation to exclude the withholding of information provides a modest but much needed protection for many patients seeking care. The requirement to provide information would potentially deal with two problems: the first-order problem of patients at religious hospitals not learning of viable alternatives to their care plans; and the second-order problem of patients not being informed that their care at a Catholic institution may involve disclosure of a limited subset of treatment options.¹⁷⁸

Current federal law does not exempt healthcare providers from a responsibility to provide information about abortion on religious grounds. Information regarding abortions is legally different from the service itself. First, the Church Amendment guarantees that religious doctors, nurses and hospitals do not need to *participate* in or be required, as a condition of receipt of federal funds, to *make facilities available* for abortion.¹⁷⁹ Additionally, while the 1997 Balanced Budget Act expanded conscience clause exemptions to reach *payors*, it did not explicitly extend that right of exemption to healthcare *providers*. Therefore, only laws at the state level grant broader conscience clause exemptions, including the right of providers to withhold information.¹⁸⁰

In addition to the absence of federal laws expressly extending conscience protections to the provision of information, medical ethics and other federal conditions of funding support requiring healthcare providers to ensure that their patients are fully informed of their health status and choices. Medical ethics regarding informed consent focus on patient autonomy and “autonomous

178. The first-order failure of information arguably runs afoul of existing duties under tort law, federal funding conditions, and the nondiscrimination of the Affordable Care Act. This second-order problem, which could induce patients to believe falsely that they are receiving the entirety of the information available, produces potentially even more dangerous outcomes. Abortion counseling has been limited in other contexts, including the Title X gag rule, which prevents family planning centers receiving federal funds from discussing abortion as an option. This rule was upheld in *Rust v. Sullivan*, 500 U.S. 173 (1991).

179. 42 U.S.C. § 300a-7 (2012).

180. See *supra* notes 40-42, 53-54 and accompanying text.

authorization” before a professional initiates medical plans.¹⁸¹ These values have been recognized under tort law,¹⁸² and they have been applied in the context of reproductive healthcare.¹⁸³ Informed consent principles are also reflected in stated federal requirements under the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation.¹⁸⁴ These conditions seek to ensure patient rights: “the right to participate in the development and implementation of his or her plan of care”¹⁸⁵ and the “right to make informed decisions regarding his or her care . . . includ[ing] being informed of his or her health status, [and] being involved in care planning and treatment.”¹⁸⁶

So the common law has historically afforded patients a right of action, and CMS Conditions of Participation express federal commitments to informed consent. The ACA’s nondiscrimination provision would bolster patients’ rights

181. JESSICA W. BERG, ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE ch. 8 (2011). The basic notion is that “one must understand that one is assuming responsibility and warranting another to proceed.” *Id.* at 280. Tort law, however, does not adequately address the systemic authorization by USCCB to decline to provide medical services and critical information. Furthermore, expansive state laws chip away at patient protections. Section 1557 changes the legal landscape by providing a means to rein in systemic practices that violate the core notions of informed consent, rather than leaving these interests to be vindicated by piecemeal litigation against individual healthcare providers.

182. This principle made its way into common law in *Schloendorff v. Society of New York Hospital*, 105 N.E. 92 (N.Y. 1914), when then-Judge Cardozo wrote that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body . . .” *Id.* at 129. Then, in 1957, in *Salgo v. Leland Stanford Jr. University Board of Trustees*, 154 Cal. App. 2d 560 (Cal. Dist. Ct. App. 1957), a California court held that physicians had an affirmative duty to disclose all relevant information to patients and held a physician liable for failing to inform a patient about possible alternative treatments. This marked the beginning of the modern concept of informed consent in the common law, and this concept became the consensus among courts in the 1960s and 1970s. See BERG ET AL., *supra* note 181, at 22, 45, 48.

183. See, e.g., *Brownfield v. Daniel Freeman Marina Hosp.*, 208 Cal. App. 3d 405, 414 (1989) (holding that “when a rape victim can allege: that a skilled practitioner of good standing would have provided her with information concerning and access to estrogen pregnancy prophylaxis [(emergency contraception)] under similar circumstances; that if such information had been provided to her she would have elected such treatment; and that damages have proximately resulted from the failure to provide her with information concerning this treatment option, said rape victim can state a cause of action for damages for medical malpractice” (internal citations omitted)); *Harbeson v. Parke-Davis, Inc.*, 656 P.2d 483 (Wash. 1983) (recognizing a wrongful death action in tort despite the presence of a statutory right to refuse to provide or participate in providing an abortion).

184. 42 C.F.R. § 482.55 (2013) (defining the requirements, under the CMS Conditions of Participation, that hospitals meet the “emergency needs of patients in accordance with acceptable standards of practice”).

185. *Id.* § 482.13(a)(1).

186. *Id.* § 482.13(b)(2).

by providing a private right of action and expressly precluding the exercise of broad state conscience clauses that allow providers to withhold information. This preemption rests not only on the general supremacy of federal law over state law, but also on the specific preemption clauses established in the ACA itself. The preemption clause of the ACA, which appears in Title I of the Act, makes clear that the ACA trumps conflicting state laws.¹⁸⁷ Federal courts, in turn, have applied this preemption clause faithfully.¹⁸⁸ In addition, Section 1557 carries a clause clarifying its interaction with state law.¹⁸⁹ The fact that Section 1557 makes this preemption so explicit—given that an assumption of preemption follows naturally from both general supremacy principles and the ACA's Title I preemption clause—evinces Congress's seriousness about the reach of this nondiscrimination provision.

The particulars of Section 1557's preemption clause provide further evidence of Congressional intent. The provision provides that “nothing in this title . . . shall be construed to . . . supersede State laws that provide additional protections against discrimination” to those expounded in 1557.¹⁹⁰ Congress not only contemplated the possibility that Section 1557 might come into conflict with state law, but also provided an explicit preemption clause making clear that Section 1557 may only *expand*, and not contract, antidiscrimination protections. This one-way impact on state antidiscrimination law becomes especially clear when considered alongside the fact that the ACA expressly does *not* exempt state conscience clauses from preemption.¹⁹¹

3. Access to Emergency Abortion in Light of Other Federal and State Laws

Section 1557 may also be understood to protect patients who require emergency abortion care, like Tamesha Means, by recognizing access to reproductive care as an antidiscrimination right. Section 1557 claims dealing with the provision of abortion specifically face two legal hurdles beyond RFRA: Title IX's abortion neutrality and the Church Amendment. Title IX's definition of sex discrimination, which Section 1557 incorporates, is explicitly “neutral” on

187. The preemption clause states that “[n]othing in this title shall be construed to preempt any State law *that* does not prevent the application of the provisions of this title.” 42 U.S.C. § 18041(d) (2012) (emphasis added).

188. See, e.g., *St. Louis Effort for AIDS v. Huff*, 996 F. Supp. 2d 798, 802 (W.D. Mo. 2014) (holding that the ACA's preemption provision “implies that [the ACA] *does* preempt any State law that prevents the ACA's operation, and in that sense the statute does little more than invoke conflict preemption.”)

189. 42 U.S.C. § 18116(b).

190. *Id.*

191. See *supra* notes 131-132 and accompanying text.

abortion. This neutrality provision, commonly referred to as the Danforth Amendment, was added as part of the Civil Rights Restoration Act in 1988.¹⁹² The text reads: “Nothing in this chapter shall be construed to require or prohibit any person . . . to provide or pay for any benefit or service . . . related to an abortion.”¹⁹³ However, the implementing regulations state that that Title IX’s “abortion neutrality” does not reach “medical procedures, benefits, services, and the use of facilities, necessary to save the life of a pregnant woman.”¹⁹⁴ Given that women presenting in a hospital setting may indeed require abortions as life-saving treatment, Title IX’s abortion neutrality does not entirely shield hospitals from providing abortion care.¹⁹⁵ Section 1557 could thus compel hospitals to provide emergency abortion care.

Section 1557 has to overcome federal conscience provisions in establishing such a mandate. The Church Amendment, passed in the wake of *Roe v. Wade*, made clear that the federal government would not, as a condition of federal funding, mandate that all hospitals make their facilities available for abortions.¹⁹⁶ While the Amendment does not contain an exception for the life or health of the woman, so that it potentially creates conflict with Section 1557, the Emergency Medical Treatment and Labor Act (EMTALA)¹⁹⁷ and the CMS

192. *Title IX Legal Manual*, U.S. DEPT. JUST., <http://www.justice.gov/crt/about/cor/coord/ixlegal.php> [<http://perma.cc/5U4N-PJY5>].

193. 20 U.S.C. § 1688 (2012).

194. Nondiscrimination on the Basis of Sex in Education Programs or Activities Receiving Federal Financial Assistance, 65 Fed. Reg. 52,869 (2000) (codified at 24 C.F.R. § 3.235(d)(1) (2001)).

195. The limited language of preserving the “life of a pregnant woman,” rather than her health or well-being, may limit the application of Title IX regarding the provision of abortion services. This language mirrors the distinction drawn by many states that provide Medicaid funding for indigent women only in cases where abortion is necessary to save the life of the woman, but not all medically indicated abortions. This distinction was upheld by the Supreme Court in *Harris v. McRae*, 448 U.S. 297 (1980).

196. 42 U.S.C. § 300a-7 (2012) (stating that receipt of public funds does not require any entity to “(A) 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, or (B) provide any personnel for the performance or assistance in the performance of any sterilization procedure or abortion if the performance or assistance in the performance of such procedures or abortion by such personnel would be contrary to the religious beliefs or moral convictions of such personnel.”).

197. 42 U.S.C. § 1395dd(b) (“If any individual . . . comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either . . . for such further medical examination and such treatment as may be required to stabilize the medical condition, or . . . for transfer of the individual to another medical facility . . .”).

Conditions of Participation¹⁹⁸ indicate that the federal government may condition funding on the availability of abortion services in limited emergency circumstances where the life or health of the patient is at risk. Furthermore, a statement in the legislative history of the Church Amendment suggests that Congress did not intend to authorize conscience claims beyond the refusal of individual healthcare providers to participate directly in abortion, such as objections by a hospital employee “who had no responsibility, directly or indirectly, with regard to the performance of [the] procedure.”¹⁹⁹ Therefore, Section 1557 does not necessarily stand in direct conflict with existing federal law.

As a result, courts should recognize that the Church Amendment’s protection of institutional medical refusals is relatively narrow compared with Section 1557’s nondiscrimination mandate. When reading the Church Amendment in the context of existing federal requirements like EMTALA and the CMS Conditions of Participation, it becomes clear that the Amendment does not exempt all duties owed to patients where an abortion may be required. Section 1557 could therefore be read to create new affirmative rights—and a new private right of action—for pregnant women like Tamesha Means who require an abortion to protect their lives. This interpretation of Section 1557 would not reach individual objecting doctors and nurses, but it would have implications for the USCCB and Catholic hospital systems that have adopted the Directives’ policies preventing abortion at the institutional level. It would also provide new federal limits on states’ ability to broadly define medical refusals.

CONCLUSION

Two trends taken together are restricting women’s access to reproductive healthcare. First, the Supreme Court’s decision in *Hobby Lobby* and state conscience laws have increased the scope of potential religious refusals, which have historically presented tremendous access problems for women. Second, hospital consolidation and clinical integration in the wake of the ACA are producing a new level of dominance by Catholic hospitals and the Ethical and Religious Directives, which mandate refusals at an increasing number of institutions. As a result, more and more of our nation’s healthcare providers can and do refuse to provide care, referrals and information to their female patients.

While the post-ACA climate has produced new access challenges for women, the ACA itself provides an explicit commitment to nondiscrimination principles and expands the definition of sex discrimination in healthcare. Section

198. 42 C.F.R. § 482.55 (2012) (“The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice.”).

199. 119 CONG. REC. S9597 (Mar. 23, 1973) (statement of Sen. Church).

1557 holds great potential to stop healthcare providers from practicing gender-based exclusion. In other words, the ACA affirms a commitment to reining in the kinds of refusals that the combination of conscience protections and merger activity have exacerbated.

The ACA's nondiscrimination provision is an as-yet unfulfilled promise of equality in healthcare. The question remains whether the ACA's novel antidiscrimination provision can provide a counterweight to medical refusals whose reach has been largely unconstrained to date.

Section 1557 might also help to connect discrimination against women on the basis of their reproductive capacity with discrimination on the basis of sex—a move that would have even broader implications for how we conceive of lived sex equality. Standing alongside Title VII and Title IX, Section 1557 could work to remedy the limited recognition of pregnancy and pregnancy-capability discrimination in Equal Protection Clause jurisprudence. Together, these statutes might provide women with meaningful protections that reach beyond our current constitutional framework in employment, education, and healthcare. As Congress and the courts increasingly equate pregnancy and pregnancy-capability discrimination with sex discrimination, our conception of gender equality stands to be strengthened.