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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT SPOKANE

STATE OF WASHINGTON, Plaintiff, v. ALEX M. AZAR II, in his official capacity as Secretary of the United States Department of Health and Human Services; and UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, Defendants.	NO. 2:19-cv-00183 COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

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I. INTRODUCTION

1. The State of Washington seeks to enjoin and set aside the U.S. Department of Health and Human Service's (HHS) May 21, 2019 Final Rule,[1] which imposes the religious views of officials at HHS on Washingtonians and individuals across the country who seek timely, medically necessary care and information about reproductive health, LGBTQ health, and end-of-life care. Echoing these views, at a Rose Garden ceremony touting the release of the rule, President Trump said: "Together we are building a culture that cherishes the dignity and worth of human life. Every child, born and unborn is a sacred gift from God."[2]

2. Washington law reflects a long tradition of respecting the religious beliefs of its citizens. At the same time, its laws have struck a balance so that no one's religious views are imposed unwillingly on another. Therefore, Washington's laws require that no health care provider's conscience-based refusal results in the denial of timely access to information and services required by prevailing medical and ethical standards.

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[1] *Protecting Statutory Conscience Rights in Health Care; Delegations of Authority*, 84 Fed. Reg. 23170 (May 21, 2019) (Final Rule), *see infra* at 33 n.6.

[2] https://www.whitehouse.gov/briefings-statements/remarks-president-trump-national-day-prayer-service/, *see infra* at 33 n.5.

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3. The Final Rule tramples Washington's careful balance of rights and interests. Instead, it imposes its absolute position on the State, its health care institutions, and its residents. In the Final Rule, HHS misinterprets several federal statutes to create a categorical, absolute right by health care providers or their employees to deny medical information and care solely on the basis of their religious or moral tenets, even when required by the corresponding medical standard of care. HHS's expansive new refusal right applies to *any* employee of a covered institution and extends its protections to non-health care providers like insurers and employers.

4. HHS assumes the power to impose its religious values on the most sensitive health decisions and relationships, purporting to preempt longstanding Washington laws protecting patients' rights. Under the Final Rule, an emergency room may refuse to provide emergency contraception to a victim of a violent sexual assault. An institution at which a pregnant women discovers that her fetus is anencephalic—developing without the major structures of the brain—may refuse counseling on all medically indicated options. A religious provider treating a patient suffering from a painful, terminal illness who desires to use the Washington Death With Dignity Act may refuse to transfer medical records to a non-objecting provider. A hospital scheduler or a health insurer's telephone representative could assert a moral objection to assisting gay or transgender individuals seeking medical care.

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5. HHS's legal interpretation violates numerous statutory limits on its authority. In the Patient Protection and Affordable Care Act, the Emergency Medical Treatment and Labor Act, and annual appropriations acts for the Title X family planning program, Congress created national standards for certain health care and health insurance coverage. The Final Rule disregards those standards. Further, in a section of the ACA addressing HHS's rulemaking authority, Congress barred HHS from adopting regulations that impede access to health care information or services, violate principles of informed consent, or undercut the ethical standards of health care professionals. The Final Rule oversteps all of these restrictions. And HHS interprets the statutory provisions that are the subject of the Final Rule so broadly as to defy Congress's clear intent, assertedly preempting state laws on the books for decades.

6. Furthermore, in violation of statutory and constitutional limits, HHS attempts to coerce Washington's compliance with the Final Rule by subjecting it to the risk of the loss of *all* federal health care funds—over $10 billion per year—if the State, its health care institutions, or its subrecipients violate the Final Rule. The Final Rule puts Washington to the Hobson's choice between enforcing its patient protection and civil rights laws and jeopardizing the federal funds that supports its Medicaid and children's health insurance programs.

7. In placing its thumb on the scales to favor religious views at the expense of patients' guaranteed access to timely and complete health information

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and care, HHS harms the most vulnerable Washingtonians. In rural areas in eastern Washington, patients seeking urgent reproductive care, end-of-life assistance, or gender-affirming surgery or treatment may be forced to travel hundreds of miles for care. By imposing an absolute duty on health care providers to accommodate the religious objections of any employee to providing *any* service to *any* patient, the Final Rule invites and sanctions discrimination against patients based on their sexual orientation or gender identity. Affluent patients will nevertheless access care that is consistent with principles of informed consent, but many rural patients and the working poor will be hostage to the particular religious views of their health care providers.

8. The Administrative Procedure Act (APA), 5 U.S.C. § 706(2), empowers the Court to enjoin and set aside agency action that is contrary to constitutional right or in excess of statutory authority, or is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law. To avert irreparable injury to the State and its residents, Washington brings this suit to declare unlawful and enjoin the Final Rule.

II. PARTIES

9. Plaintiff the State of Washington is represented by its Attorney General, who is the State's chief legal adviser. The powers and duties of the Attorney General include acting in federal court on matters of public concern to the State.

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10. Washington is directly affected by the Final Rule. Washington brings this action to redress harms to its sovereign, proprietary, and quasi-sovereign interests and its interests as *parens patriae* in protecting the health and well-being of its residents.

11. Washington and its residents will suffer significant and irreparable harm if the Final Rule goes into effect.

12. Defendant Alex M. Azar II is the Secretary of HHS (the Secretary). He is sued in his official capacity.

13. Defendant HHS is the federal agency responsible for implementing the Final Rule. HHS promulgated the Final Rule challenged in this lawsuit. HHS's sub-agency, the Office of Civil Rights (OCR), administers regulations created by the Final Rule.

III. JURISDICTION AND VENUE

14. This Court has jurisdiction pursuant to 28 U.S.C. § 1331 (action arising under the laws of the United States), 28 U.S.C. § 1346 (United States as a defendant), and 5 U.S.C. §§ 701–706 (APA). An actual controversy exists between the parties within the meaning of 28 U.S.C. § 2201(a), and this Court may grant declaratory relief, injunctive relief, and other relief pursuant to 28 U.S.C. §§ 2201–2202 and 5 U.S.C. §§ 705–706.

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15. Defendants' publication of the Final Rule in the Federal Register on May 21, 2019, constitutes a final agency action and is therefore judicially reviewable within the meaning of the APA. 5 U.S.C. §§ 704, 706.

16. Venue is proper in this Court pursuant to 28 U.S.C. § 1391(e) because this is a judicial district in which the State of Washington resides and this action seeks relief against federal agencies and officials acting in their official capacities. *See California v. Azar*, 911 F.3d 558, 569–70 (9th Cir. 2018).

IV. RELEVANT FACTS

A. Federal Statutory and Regulatory Background

17. Congress has enacted into law both affirmative requirements to ensure Americans' access to modern and effective health care and conscience protections for health care providers who refuse to perform certain services.

1. Federal laws that protect patients and assure access to modern health care

a. The Patient Protection and Affordable Care Act's contraceptive coverage requirement

18. In 2010, Congress enacted the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152) (collectively, the ACA). The ACA imposes an obligation on insurers to provide contraceptive coverage. 42 U.S.C. § 300gg-13(a)(4).

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19. A limited exemption from the contraceptive coverage mandate exists for religious employers (defined as "churches, their integrated auxiliaries, and conventions or associations of churches," and "the exclusively religious activities of any religious order" that are organized and operate as nonprofit entities). In addition, for certain non-exempt employers with religious beliefs that conflict with the use of contraceptives, federal law contains an accommodation. This accommodation is intended to ensure, in the words of the Supreme Court, that eligible non-church organizations can follow "an approach going forward that accommodates [their] religious exercise while at the same time *ensuring that women covered by [their] health plans 'receive full and equal health coverage, including contraceptive coverage*.' " *Zubik v. Burwell*, 136 S. Ct. 1557, 1559 (2016) (per curiam) (emphasis added).

20. Eight courts of appeals have concluded that requiring religious objectors to notify the government of their objection to providing contraceptive coverage, so that the government can ensure that the responsible insurer or third-party administrator steps in to meet the ACA's requirements, does not impose a substantial burden on religious exercise.

b. The Emergency Medical Treatment and Labor Act

21. In 1986, Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA) to ensure public access to emergency services regardless of a patient's ability to pay. 42 U.S.C. § 1395dd.

22. Under EMTALA, a hospital must provide patients with a medical screening examination and, if the patient has an "emergency medical condition," provide stabilizing treatment or execute an appropriate transfer. 42 U.S.C. § 1395dd; 42 C.F.R § 489.24. The term "emergency medical condition" includes "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy . . . ." 42 U.S.C. § 1395dd(e)(1).

23. Hospitals and physicians violating EMTALA are subject to civil monetary penalties and the threat of Medicare decertification. 42 U.S.C. § 1395dd(d).

c. The mandate for non-directive pregnancy counseling in the appropriations acts applicable to the Title X family planning program

24. In 1970, Congress enacted the Family Planning Services and Population Research Act of 1970, 42 U.S.C. § 300, *et seq.*, which added Title X to the Public Health Service Act. Title X seeks to help low-income women reduce their rate of unintended pregnancies and exercise control over their economic lives and health by offering federally-funded access to effective contraception and reproductive health care. The statute requires the HHS Secretary to award grants to state or local governments and non-profit organizations for the

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"establishment and operation of voluntary family planning projects" to provide contraception and other reproductive health care, with priority given to persons from low-income households. 42 U.S.C. §§ 300(a), 300(b), 300a-4(c)(1).

25. Since 1996, Congress has passed annual appropriations acts applicable to HHS requiring that all pregnancy counseling within a Title X program *must* be nondirective.[3] Under this non-directive mandate, all recipients of Title X grant funds must ensure that patients determined to be pregnant receive "information on all available options without promoting, advocating, or encouraging one option over another." 83 Fed. Reg. 25512, n.41 (Jun. 1, 2018).

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[3] *See* Pub. L. No. 115-245 (Sept. 28, 2018); Pub. L. No. 115-141 (Mar. 23, 2018); Pub. L. No. 115-31 (May 5, 2017); Pub. L. No. 114-113 (Dec. 18, 2015); Pub. L. No. 113-76 (Jan. 17, 2014); Pub. L. No. 113-235 (Dec. 16, 2014); Pub. L. No. 112-74 (Dec. 23, 2011); Pub. L. No. 111-117 (Dec. 16, 2009); Pub. L. No. 111-8 (Mar. 11, 2009); Pub. L. No. 111-322 (Dec. 22, 2010); Pub. L. No. 110-161 (Dec. 26, 2007); Pub. L. No. 109-149 (Dec. 30, 2005); Pub. L. No. 108-199 (Jan. 23, 2004); Pub. L. No. 108-7 (Feb. 20, 2003); Pub. L. No. 108-447 (Dec. 8, 2004); Pub. L. No. 107-116 (Jan. 10, 2002); Pub. L. No. 106-554 (Dec. 21, 2000); Pub. L. No. 106-113 (Nov. 29, 1999); Pub. L. No. 105-78 (Nov. 13, 1997); Pub. L. No. 105-277 (Oct. 21, 1998); Pub. L. No. 104-134 (Apr. 26, 1996); Pub. L. No. 104-208 (Sept. 30, 1996).

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26. Congress's non-directive mandate requires that pregnant Title X patients receive information on abortion upon request. HHS explicitly adopted recommendations made by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics stating that "[i]f the patient indicates that the pregnancy is unwanted, she should be fully informed in a balanced manner about all options, including raising the child herself, placing the child for adoption, and abortion." American Academy of Pediatrics & The American College of Obstetricians & Gynecologists (ACOG), Guidelines for Perinatal Care, p. 127 (7th ed. 2016).[4] Congress did not create a conscience-based right for the voluntary applicants for Title X grants to refuse to comply with the non-directive mandate.

d. The ACA bars HHS regulations that deny patients timely access to medical care, interfere with provider-patient communications, or undermine informed consent or medical ethics

27. In passing the ACA in 2010, Congress enacted a statutory section that preserves the sanctity and integrity of the patient-provider relationship by prohibiting interference by federal regulators. Section 1554 bars HHS from

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[4] *See Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*, Morbidity and Mortality Weekly Report Vol. 63, No. 4 (April 25, 2014), *available at* https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf (last accessed January 2, 2019).

adopting any regulations that impede patients' access to medical information and quality care. Section 1554 provides that the Secretary of HHS "shall not promulgate any regulation" that, *inter alia*:

1. creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care;
2. impedes timely access to health care services;
3. interferes with communications regarding a full range of treatment options between the patient and the provider;
4. restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions; or
5. violates the principles of informed consent and the ethical standards of health care professionals.

42 U.S.C. § 18114.

28. In addition to federal health care laws that balance conscience rights with Americans' right to timely and modern health care, federal civil rights laws balance the protection of religious beliefs against employers' needs to manage their business affairs. Title VII of the Civil Rights Act of 1964 prohibits discrimination in employment based on religious beliefs. 42 U.S.C. § 2000e-2(a). It also provides that employers are not obligated to accommodate employees' religious beliefs where they would cause "undue hardship" on the employer's business. 42 U.S.C. § 2000e(j). Freedom of religion "gives no one the right to insist that in pursuit of their own interests others must conform their conduct to

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his own religious necessities." *Otten v. Baltimore & O.R. Co.*, 205 F.2d 58, 61 (2d Cir. 1953).

29. HHS expressly declined to incorporate an assessment of undue burden on employers in its categorical protection of conscience rights. 84 Fed. Reg. 23191 (May 21, 2019). The Final Rule fails to address how HHS will determine if Washington's health care institutions engaged in "discrimination" where an employee's absolute right to refuse information and care on conscience grounds conflicts with Title VII's balancing test.

2. Federal refusal laws that protect conscience-based objections to providing certain health care services

a. The Church Amendments

30. Under the Church Amendments, entities that receive certain federal funds cannot require that individuals perform or assist in performing any sterilization procedure, abortion, or other health care programs or research if doing so would be contrary to religious beliefs or moral convictions. Entities cannot be required to make their facilities available for any sterilization procedure or abortion if the procedure is prohibited based on the entity's religious beliefs or moral convictions.

31. Entities that receive certain federal funds (including those who receive HHS grants or contracts for biomedical or behavioral research) cannot discriminate in employment, promotion, termination, or the extension of staff or other privileges because a provider performed or assisted in the performance of

a lawful sterilization procedure or abortion—or refused to do so based on religious beliefs or moral convictions.

32. There are similar protections for those who apply to health care training or study programs, including internships and residencies. Individuals cannot be denied admission or discriminated against based on their willingness or unwillingness to counsel, suggest, recommend, assist, or participate in performing an abortion or sterilization if doing so is contrary to their religious beliefs or moral convictions.

b. The Coats-Snowe Amendment

33. The Coats-Snowe Amendment prohibits government entities that receive federal financial assistance from discriminating against health care entities (including physicians and those in health professional training programs) that refuse to undergo training to perform abortions, refuse to provide referrals for abortions or abortion training, or refuse to make arrangements for those activities. Discrimination could occur if, for instance, the government denied an entity a license to operate or refused financial assistance, services, or other benefits. This amendment also applies to the accreditation of postgraduate physician training programs.

c. The Weldon Amendment

34. The Weldon Amendment has been included in annual appropriations acts since 2004 and restricts the use of federal funds provided

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through the Departments of Labor and HHS appropriations bill. The Weldon Amendment prohibits government entities from using these funds to discriminate against health care entities because they do not provide, pay for, cover, or refer for abortions. There are similar appropriations laws that prohibit HHS from barring a provider-sponsored organization from participating in Medicare Advantage because it will not provide, pay for, cover, or refer for abortions.

d. Refusal rights in the ACA

35. The ACA included a number of health care conscience provisions. Under Section 1303, health plans are not required to cover abortion services as part of the essential health benefits package and cannot discriminate against providers or facilities because of their unwillingness to provide, pay for, cover, or refer for abortions. The individual mandate includes a religious conscience exemption for members of a health care sharing ministry and organizations or individuals that oppose insurance benefits for religious reasons. Section 1553 of the ACA prohibits government entities that receive federal financial assistance under the ACA from discriminating against an individual or health care entity because of an objection to providing items or service related to assisted suicide.

e. Other federal statutory refusal rights

36. Other federal health care conscience laws prohibit Medicare and Medicaid providers, organizations, or employees—including hospitals, skilled nursing facilities, hospice programs, Medicaid managed care organizations, and

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Medicare Advantage plans—from being required to inform or counsel an individual about a right to an item or service related to assisted suicide or advance directives. Medicare Advantage plans and Medicaid managed care organizations cannot be compelled to provide, reimburse for, or cover counseling or referrals that they object to on moral or religious grounds.

B. Washington Laws Guaranteeing Timely Access to Health Care and Respecting Conscience-Based Refusal Rights

1. Washington's statutory conscience protection statute

37. Washington's legislature has crafted a careful balance between individuals' religious and moral beliefs and patients' rights to health care.

38. Washington law states:

> The legislature recognizes that every individual possesses a fundamental right to exercise their religious beliefs and conscience. The legislature further recognizes that in developing public policy, conflicting religious and moral beliefs must be respected. Therefore, while recognizing the right of conscientious objection to participating in specific health services, the state shall also recognize the right of individuals enrolled with plans containing the basic health plan services to receive the full range of services covered under the plan.

Wash. Rev. Code 48.43.065; *see also* Wash. Rev. Code 70.47.160.

39. Consistent with this legislative goal, the conscience protection statute clarifies that "[n]o individual health care provider, religiously sponsored health carrier, or health care facility may be required by law or contract in any circumstances to participate in the provision of or payment for a specific service if they object to so doing for reason of conscience or religion." Wash. Rev. Code

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48.43.065(2)(a). Nor are individuals or organizations with a religious or moral tenet "required to purchase [insurance] coverage for that service or services if they object to doing so for reason of conscience or religion." Wash. Rev. Code 48.43.065(2)(b); *see also* Wash. Rev. Code 70.47.160(2)(b). The statute also protects persons from discrimination "in employment or professional privileges" because they assert a conscience objection. Wash. Rev. Code 48.43.065(2)(a); *see also* Wash. Rev. Code 70.47.160(2)(a).

40. While recognizing the right of conscientious objection to participating in specific health services, the statutes also recognize "the right of individuals enrolled with plans . . . to receive the full range of services covered under the plan." Wash. Rev. Code 48.43.065(1); *see also* Wash. Rev. Code 70.47.160(1). The exercise of conscience rights cannot deprive an individual of "coverage" or "timely access to" medical services. Wash. Rev. Code 48.43.065(3)(b); *see also* Wash. Rev. Code 70.47.160(3)(b).

41. As discussed further, below, Washington public policy and health care statutes incorporate principles reflecting a recognition of conscience rights, while also respecting the rights of Washington residents to receive appropriate and fully informed medical care as required by federal law, state law, and longstanding medical standards and ethical rules.

2. The Reproductive Privacy Act, Wash. Rev. Code 9.02.100, *et seq.*

42. Washington's longstanding public policy supports women's access to a full range of reproductive health care services, including abortion. In 1970, three years before *Roe v. Wade*, 410 U.S. 113 (1973), Washington voters passed Referendum 20, becoming the first state to legalize elective abortion through the popular vote. Referendum 20 permitted abortions within the first four months of pregnancy when performed by, or under the supervision of, a licensed physician. Laws of 1970, 2d Ex. Sess., ch. 3, § 2. By the mid-1970s, the state was providing public funding for abortions for indigent women, which it continued to do after federal funding was eliminated.

43. In 1991, Washingtonians again voted in favor of abortion rights, adding detail and clarifying the proper role of the state. Laws of 1992, ch. 1, §§ 1–13. Initiative 120, the Reproductive Privacy Act, declares that the "right of privacy with respect to personal reproductive decisions" is a "fundamental right" of each individual. Wash. Rev. Code 9.02.100. The Act prohibits the state from discriminating against, denying, or interfering with a woman's "right to choose to have an abortion prior to viability of the fetus, or to protect her life or health." Wash. Rev. Code 9.02.100(4), .110. Any restriction on abortion is valid only if it is medically necessary to protect the life or health of the woman, consistent with established medical practice, and the least restrictive of all available alternatives. Wash. Rev. Code 9.02.140.

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44. Washington has always respected the conscience rights of providers who object to providing abortion services. The 1970 ballot measure legalizing elective abortion provided that "[n]o hospital, physician, nurse, hospital employee nor any other person shall be under any duty . . . to participate in a termination of pregnancy if such hospital or person objects to such termination." Laws of 1970, 2d Ex. Sess., ch. 3, § 3. The 1991 Reproductive Privacy Act refined and replaced the language governing who may object, providing that "[n]o person or private medical facility may be required by law or contract in any circumstances to participate in the performance of an abortion if such person or private medical facility objects to so doing." Wash. Rev. Code 9.02.150.

3. The Reproductive Parity Act, Wash. Rev. Code 48.43.072–.073

45. In 2018, the Washington Legislature passed, and the Governor signed, SSB 6219 (codified as Wash. Rev. Code 48.43.072 and .073), entitled the Reproductive Parity Act. The Reproductive Parity Act requires that health plans provide contraceptive coverage, and that a health plan providing coverage for maternity care or services also include coverage for equivalent abortion services. In the Act, the Washington Legislature declared that:

- Reproductive health care is the care necessary to support the reproductive system, the capability to reproduce, and the freedom and services necessary to decide if, when, and how often to do so, which can include contraception, cancer and disease screenings, abortion, preconception, maternity, prenatal, and postpartum care. This care is an essential part of primary care for women and teens, and often reproductive health issues are the primary reason they seek routine medical care;

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- Neither a woman's income level nor her type of insurance should prevent her from having access to a full range of reproductive health care, including contraception and abortion services;
- Restrictions and barriers to health coverage for reproductive health care have a disproportionate impact on low-income women, women of color, immigrant women, and young women, and these women are often already disadvantaged in their access to the resources, information, and services necessary to prevent an unintended pregnancy or to carry a healthy pregnancy to term;
- This state has a history of supporting and expanding timely access to comprehensive contraceptive access to prevent unintended pregnancy;
- Nearly half of pregnancies in both the United States and Washington are unintended. [. . .]
- Access to contraception has been directly connected to the economic success of women and the ability of women to participate in society equally.

Reproductive Parity Act, 2018 Wash. Sess. Laws, ch. 119 (SSB 6219).

46. Relevant here, the law has two parts. First, health plans issued or renewed after January 1, 2019 must provide coverage for all contraceptives approved by the federal Food and Drug Administration, voluntary sterilization procedures, and any services necessary to provide the contraceptives. Wash. Rev. Code 48.43.072(1). This coverage cannot be subject to cost sharing or a deductible, unless the health plan is part of a health savings account. Wash. Rev. Code 48.43.072(2)(a). Carriers cannot deny coverage because an enrollee changed a contraceptive method changed within a twelve-month period, and the

health plan cannot impose any restrictions or delays on the enrollee's ability to receive this coverage. Wash. Rev. Code 48.43.072(3), (4). These benefits must be offered to all enrollees, their enrolled spouses, and their enrolled dependents. Wash. Rev. Code 48.43.072(5).

47. Second, health plans issued or renewed after January 1, 2019, that provide coverage for maternity care or services must "also provide a covered person with substantially equivalent coverage to permit the abortion of a pregnancy." Wash. Rev. Code 48.43.073(1).

48. During public testimony on SSB 6219, opponents argued that the bill would "violate the constitutionally protected rights of religious organizations and individuals." Senate Bill Report, SSB 6219 at 5, *available at* http://lawfilesext.leg.wa.gov/biennium/2017-18/Pdf/Bill%20Reports/Senate/6219%20SBR%20WM%2018.pdf (last accessed May 23, 2019). Proponents responded that the bill represented "a compromise . . . that protects religious organizations but still protects women's reproductive health." *Id.* Those with conscience or religious objections could still utilize the protections of Wash. Rev. Code 48.43.065 to avoid purchasing services with which they hold a moral or religious objection. Wash. House Health Care & Wellness Comm., Public Hrg., Feb. 7, 2018 at 33:12–39:30, *available at* https://www.tvw.org/watch/?eventID=2018021058 (last accessed Apr. 17, 2019).

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49. The Insurance Commissioner has proposed new rules implementing SSB 6219. Office of the Insurance Commissioner, *Health Plan Coverage of Reprod. Healthcare and Contraception Stakeholder Draft*, Sept. 20, 2018, *available at* https://www.insurance.wa.gov/sites/default/files/2018-09/2018-10-stakeholder-draft.pdf (last accessed April 17, 2019). The proposed rules make clear that SSB 6219 does not preclude someone from exercising their rights under Wash. Rev. Code 48.43.065: "This subchapter does not diminish or affect any rights or responsibilities provided under [Wash. Rev. Code] 48.43.065." *Id.* at 2.

4. Informed consent, Wash. Rev. Code 7.70.050–.060

50. Washington State also recognizes a patient's right to determine the course of their own medical treatment. Under Washington law, providers are under a non-delegable fiduciary duty to obtain a patient's informed consent before engaging in a course of treatment. Wash. Rev. Code 7.70.050.

51. Unless a patient has been provided all the information necessary to make a knowledgeable decision regarding their medical care, the patient's "consent" to the course of action taken by the health care provider is not "informed." The broad categories of information that must be disclosed to the patient include: (1) the nature, character and anticipated results of the treatment, (2) material risks inherent in the proposed treatment, and the (3) alternative courses of treatment and their attendant risks. Wash. Rev. Code 7.70.060(1).

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52. Consequently, if medical evidence establishes that there is an alternative course of treatment, including nontreatment, the physician has a duty to inform the patient of that alternative. *Archer v. Galbraith*, 18 Wash. App. 369, 379, 567 P.2d 1155 (1977).

53. Washington hospitals also play a role in the informed consent process. They must ensure the patient's right to be involved in all aspects of their care including obtaining informed consent. Wash. Admin Code 246-330-125 (requiring that ambulatory surgical facilities provide their patients with a copy of their rights which include, among other things, the right to "[b]e informed and agree to their care."); Wash. Admin. Code 246-320-166(4)(c) (requiring hospitals to include "consent documents" as part of a patient's medical records).

54. Washington's informed consent statute is consistent with longstanding medical standard of care principles and medical ethics. By way of example, in the context of reproductive care, medical providers are ethically required to provide a patient with "pertinent medical facts and recommendations consistent with good medical practice." ACOG, Code of Professional Ethics, *available at* https://www.acog.org/About-ACOG/ACOG-Departments/Committees-and-Councils/Volunteer-Agreement/Code-of-Professional-Ethics-of-the-American-College-of-Obstetricians-and-Gynecologists (last accessed May 23, 2019); *see also* American Medical Association, AMA Code of Medical Ethics (2016) *available at* https://www.ama-assn.org/sites/ama-assn.org/

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files/corp/media-browser/code-of-medical-ethics-chapter-2.pdf (last accessed May 23, 2019) (a provider that withholds medical information is in violation of the medical code of ethics).

55. To that end, medical providers counseling pregnant patients must provide "complete, medically accurate and unbiased information and resources for all of their pregnancy options," including prenatal care, abortion, and other options for which the patient may want information. ACOG Executive Board, Abortion Policy 2014 Statement Of Policy 1, *available at* https://www.acog.org/-/media/Statements-of-Policy/Public/sop069.pdf (last accessed May 23, 2019); *see also* ACOG, Comm. on Ethics, *Opinion No. 528, Adoption*, 119 Obstetrics & Gynecology 1320, 1320 (2012), *available at* https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/Adoption (last accessed May 23, 2019) (reaffirmed in 2018). In order to be fully informed, the discussion between the health care provider and the patient must also take place in an environment free from personal bias, coercion, or undue influence.

56. Washington's informed consent statute does not conflict with conscience principles. A medical provider does not have to participate in procedures to which they object on moral or religious grounds, but, as a matter of law, they have not obtained the requisite informed consent if they withhold information related to those medical procedures from their patient.

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5. Regulation of pharmacies' responsibilities, Wash. Admin Code 246-869-010

57. The practice of pharmacy in the state of Washington is regulated by the Washington Pharmacy Quality Assurance Commission pursuant to a comprehensive regulatory scheme that directs the Commission, among other responsibilities, to "[r]egulate the practice of pharmacy and enforce all laws placed under its jurisdiction" and "[p]romulgate rules for the dispensing, distribution, wholesaling, and manufacturing of drugs and devices and the practice of pharmacy for the protection and promotion of the public health, safety, and welfare." Wash. Rev. Code 18.64.005. The "practice of pharmacy" "includes the practice of and responsibility for: [i]nterpreting prescription orders [and] the compounding, dispensing, labeling, administering, and distributing of drugs and devices," in addition to information-sharing and monitoring responsibilities. Wash. Rev. Code 18.64.011(11).

58. In January 2006, the predecessor to the Commission, the Washington Board of Pharmacy, became concerned with the lack of clear authority regarding destruction or confiscation of lawful prescriptions and refusals by pharmacists to dispense lawfully prescribed medications. Recognizing the importance of providing Washington patients timely access to all medications, the Board initiated a rulemaking process to address these issues. *See Stormans, Inc. v. Selecky*, 586 F.3d 1109, 1114 (9th Cir. 2009).

59. After considering a number of draft rules, the Board adopted two rules by unanimous vote on April 12, 2007. The first rule, an amendment to Wash. Admin. Code 246-863-095, governs pharmacists. Under this rule, a pharmacist may be subject to professional discipline for destroying or refusing to return an unfilled lawful prescription, violating a patient's privacy, or unlawfully discriminating against, or intimidating or harassing a patient. The rule, however, does not require an individual pharmacist to dispense medication in the face of a personal objection.

60. The second rule, Wash. Admin. Code 246-869-010, governs pharmacies. It requires pharmacies "to deliver lawfully prescribed drugs or devices to patients and to distribute drugs and devices approved by the U.S. Food and Drug Administration for restricted distribution by pharmacies . . . in a timely manner consistent with reasonable expectations for filling the prescription." Wash. Admin Code 246-869-010(1). A pharmacy may substitute a "therapeutically equivalent drug" or provide a "timely alternative for appropriate therapy," but apart from certain necessary exceptions, a pharmacy is prohibited from refusing to deliver a lawfully prescribed or approved medicine. Wash. Admin. Code 246-869-010(1), (3), (4). A pharmacy is also prohibited from destroying or refusing to return an unfilled lawful prescription, violating a patient's privacy, unlawfully discriminating against, or intimidating or harassing a patient. Wash. Admin Code 246-869-010(4).

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61. In the Concise Explanatory Statement accompanying the regulations, the Board noted that it created a right of refusal for individual pharmacists by allowing a pharmacy to accommodate a pharmacist who has a religious or moral objection. A pharmacy may not refer a patient to another pharmacy to avoid filling a prescription because the pharmacy has a duty to deliver lawfully prescribed medications in a timely manner. A pharmacy may accommodate a pharmacist's personal objections in any way the pharmacy deems suitable, including having another pharmacist available in person or by telephone.

6. Washington Charity Care Law, Wash. Rev. Code 70.170.060

62. Washington has enacted charity care legislation that requires hospitals to provide free or discounted inpatient and outpatient care to low income patients. Washington's law requires that hospitals and their staff provide emergency care to patients regardless of their ability to pay. Wash. Rev. Code 70.170.060. Similar to the federal EMTALA, a patient in an emergency medical condition or active labor cannot be transferred unless by patient request or because the hospital has limited medical resources. Wash. Rev. Code 70.170.060(2). A transfer must follow reasonable procedures, which include but are not limited to confirming that the receiving hospital accepts the transfer. *Id.*

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7. Emergency contraception for sexual assault victims, Wash. Rev. Code 70.41.350

63. Emergency contraception prevents pregnancy, and is commonly used after a sexual assault. Washington law (Wash. Rev. Code 70.41.350) and the rules to enact it (Wash. Admin. Code 246-320-286) require all hospitals with emergency rooms to provide emergency contraception as a treatment option to any woman who seeks treatment as a result of a sexual assault.

64. Hospitals providing emergency care to a victim of sexual assault must: (1) develop and implement policies and procedures regarding the provision of twenty-four-hour/seven-days per week emergency care to victims of sexual assault; (2) provide the victim of sexual assault with medically and factually accurate and unbiased written and oral information about emergency contraception; (3) orally inform each victim in a language she understands of her option to be provided emergency contraception at the hospital; and (4) immediately provide emergency contraception if the victim requests it, and if the emergency contraception is not medically contraindicated. Wash. Admin. Code 246.320.286.

8. Duty to comply with advanced directives, Wash. Rev. Code 70.122.030

65. Washington residents may execute a directive that requires health care providers to withhold or withdraw life-sustaining treatment if they are a terminal or semi-conscious condition. Wash. Rev. Code 70.122.030. These directives become a part of the patient's medical records and are forwarded to the

patient's health care facility. Under Washington law, no nurse, physician or other health care provider can be required to participate in the withholding or withdrawal of life sustaining treatment if they have an objection. Wash. Rev. Code 70.122.060(2). When an attending physician or health care facility becomes aware of a patient's advance directive, however, they *must* inform the patient of any policy or practice that would preclude them from honoring the patient's directive. Wash. Rev. Code 70.122.060(2).

9. Information concerning end-of-life care options, Wash. Rev. Code 70.245

66. Washington State recognizes that residents suffering a terminal disease may make an informed decision to self-administer medication to end their own life in a humane and dignified manner. The Washington Death with Dignity Act, Initiative 1000 (DWDA), passed by popular vote on November 4, 2008 and went into effect on March 5, 2009. Wash. Rev. Code 70.245. Under the DWDA, terminally ill adults seeking to end their life may request lethal doses of medication from medical and osteopathic physicians.

67. The DWDA requires a patient to make two oral requests for life ending medications, and that they submit a written request with specific information which must be signed by two qualified witnesses. Wash. Rev. Code 70.245.030. Two physicians, a prescribing physician and a consulting physician, must confirm the patient's terminal diagnosis, the patient's intent to end their life, and the patient's capacity to make an informed decision. Wash. Rev. Code

70.245.070; *see also* Wash. Rev. Code 70.245.120. A patient must then wait forty-eight hours before receiving life-ending medication, and must self-administer the medication.

68. The DWDA acknowledges the conscience rights of providers, explicitly stating that providers are not required to "participate" in a patient's request under the DWDA. Wash. Rev. Code 70.245.190. In addition, it allows health care facilities to take adverse action against attending physicians, consulting physicians and any individuals who perform a counseling function if they participate in the DWDA despite knowing that the health care provider has policies against providing DWDA services. Wash. Rev. Code 70.245.190(2)(b). Among other things, a non-participating health care facility can terminate privileges and employment. *Id.*

69. The DWDA defines "participation" narrowly, however, and does not permit sanctions if the counselor, attending physician or consulting physician is simply providing information about the Washington DWDA, or providing a referral to another physician upon a patient's request. Wash. Rev. Code 70.245.190(d). If a health care provider is unwilling to carry out the request, and the patient transfers his or her care to a new health care provider, the non-participating provider must transfer, upon request, a copy of the patient's relevant medical records. *Id.*

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10. Services for LGBTQ individuals

70. In 2019, the Washington Legislature passed, and the Governor signed, 2SSB 5602, entitled "An Act relating to eliminating barriers to reproductive health care for all." The Act resulted from a report submitted to the Legislature on January 1, 2019. The report was generated in response to a legislatively mandated review of barriers to reproductive health care. In response to this report, the Legislature found that "Washingtonians who are transgender and gender nonconforming have important reproductive health care needs . . . [which] go unmet when, in the process of seeking care, transgender and gender nonconforming people are stigmatized or are denied critical health services because of their gender identity or expression." 2019 Wash. Sess. Laws, ch. 399, § 1(3). Thus, the Legislature found that "all Washingtonians, regardless of gender identity, should be free from discrimination in the provision of health care services, health care plan coverage, and in access to publicly funded health coverage." *Id.* § 1(6).

71. Relevant here, the Act prohibits programs regulated by the Washington State Health Care Authority from discriminating based on gender identity or expression. The Washington State Health Care Authority is the largest health care purchaser in Washington and purchases health care for Washington residents through Apple Health (Medicaid), the Public Employees Benefits Board Program, and beginning in 2020, the School Employees Benefit Board

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Program. Specifically, the Act amends chapter 74.09 Wash. Rev. Code to provide that: "In the provision of reproductive health care services through programs under this chapter, the [Health Care Authority], managed care plans, and providers that administer or deliver such services may not discriminate in the delivery of a service provided through a program of the authority based on the covered person's gender identity or expression." 2019 Wash. Sess. Laws, ch. 399, § 2(1).

72. The Act further clarifies that it shall be prohibited discrimination under chapter 49.60 Wash. Rev. Code for the Health Care Authority or any managed care plan delivering services purchased or contracted for by the authority to make any "automatic initial denials of coverage for reproductive health care services that are ordinarily or exclusively available to individuals of one gender, based on the fact that the individual's gender assigned at birth, gender identity, or gender otherwise recorded in one or more government-issued documents, is different from the one to which such health services are ordinarily or exclusively available." *Id.* § 2(2) and (3). The Act takes effect on July 28, 2019.

11. Patient abandonment

73. In 1942, the Washington Supreme Court established the rule on the appropriate manner of a provider to withdraw patient care: "It is the general rule that when a physician undertakes to treat a patient, it is his duty to continue to

devote his best attention to the case until either medical attention is no longer needed, he is discharged by the patient, or he has given the patient reasonable notice of his intention to cease to treat the patient, so that another physician may be obtained." *Gray v. Davidson*, 15 Wash. 2d 257, 266–267, 130 P.2d 341 (1942). Washington has incorporated these principles in a number of statutes and regulations addressing the practice of medicine and the provision of medical services. *E.g.*, Wash. Admin. Code 246-840-710 (abandoning a patient without an appropriate transfer constitutes a violation of the standards of nursing conduct and practice).

74. The Washington State Medical Association acknowledges that physicians may choose whom to serve pursuant to their conscience objection. However, "other principles balance this prerogative with obligations to respect patients and their ability to access available medical care. Therefore, a conscientious objection should, under most circumstances, be accompanied by a referral to another physician or health care facility." WSMA Policy Compendium, *available at* https://wsma.org/WSMA/About/Policies/Policies.aspx (last accessed May 23, 2019).

C. HHS's 2019 Final Rule

1. Background

75. On May 2, 2019, President Trump announced the finalization of the rule in a Rose Garden speech during the National Day of Prayer Service.[5] Directly after that announcement, President Trump said, "Together we are building a culture that cherishes the dignity and worth of human life. Every child, born and unborn is a sacred gift from God." That day, HHS published the text of the Final Rule on its website.

76. On May 21, 2019, HHS issued the Final Rule[6] to expand and consolidate its Office of Civil Rights' (OCR) enforcement authority over nearly

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[5] Remarks by President Trump at the National Day of Prayer Service, May 2, 2019, *available at* https://www.whitehouse.gov/briefings-statements/remarks-president-trump-national-day-prayer-service/ (last accessed May 23, 2019).

[6] *Protecting Statutory Conscience Rights in Health Care; Delegations of Authority*, 84 Fed. Reg. 23170 (May 21, 2019), *available at* https://www.govinfo.gov/content/pkg/FR-2019-05-21/pdf/2019-09667.pdf?utm_campaign=subscription%20mailing%20list&utm_source=federalregister.gov&utm_medium=email (last accessed May 22, 2019). The PDF version of the Final Rule on the Federal Register website, linked at note 1, erroneously dates it one year prior, May 21, 2018. The version posted on the Federal Register website

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thirty federal health care conscience laws, including three parts of the ACA. These laws focus largely on abortion but some also address sterilization procedures, health care counseling, physician-assisted suicide, and advance directives, among other types of medical care.

77. The Final Rule dramatically expands the reach of the federal statutes it purports to interpret. It makes the refusal rights of individuals and institutions absolute and categorical. It broadly allows providers to refuse to engage in health care counseling, so that patients may not even know they are being denied knowledge of their full range of options. It applies not just to health care professionals but to any employee, so a clinic receptionist or a health insurer's customer representative may refuse to perform their normal work responsibilities. It also applies to non-health care providers such as insurance companies and non-health employers. And States are required to police their subrecipients' compliance with the Final Rule if they receive any federal funds, so that an unknown violation of the rule by a recipient of a pass-through of HHS financial assistance could result in the termination of the State's entire multi-billion dollar federal Medicaid match.

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bears the correct date of May 21, 2019. *See* https://www.federalregister.gov/documents/2019/05/21/2019-09667/protecting-statutory-conscience-rights-in-health-care-delegations-of-authority (last accessed May 23, 2019).

78. The substantive provisions of the Final Rule attempt to track the statutory language of the nearly thirty laws. However, the Rule defines many key terms—such as "discrimination," "health care entity," and "referral"—in ways that significantly broaden the prior application of these laws. The Final Rule now applies to entities that include state governments, federally recognized tribes, hospitals, skilled nursing facilities, home health care providers, doctor's offices, front desk staff, insurance companies, ambulance providers, pharmacists, pharmacies, and many non-health employers that offer insurance to their employees.

2. Definitions section

79. The definitions section of the Final Rule includes a number of changes to prior definitions, as well as newly defined terms.

a. "Assist in the performance"

80. The Church Amendments prohibit individuals from being forced to perform or "assist in the performance" of procedures or health care services involving abortion or sterilization that are contrary to their religious beliefs or moral convictions. The Final Rule defines "assist in the performance" as taking an action that has a specific, reasonable, and articulable connection to furthering a procedure or part of a health service program or research activity undertaken by or with another person or entity. This may include counseling, referral,

training, or otherwise making arrangements for the procedure, program, or research activity.

81. This definition extends to non-medical staff (such as front desk staff) and other segments of the health care workforce (such as ambulance drivers). HHS states that a person preparing a room for an abortion or scheduling an abortion could fall under the definition—as could driving a person to a hospital or clinic with a ruptured ectopic pregnancy, where termination of the pregnancy is a reasonable likelihood. Emergency medical technicians and paramedics may claim protection under the rule.

82. Two sections of this definitional section are dramatic in their breadth. One purports to make options counseling completely discretionary for providers and institutions with conscience-based objections, even if the options are medically indicated for the patient's condition. HHS defines "assist in the performance" to encompass medical counseling, including informing patients of their available options under the applicable standard of care. Final Rule § 88.2. Thus, the Final Rule makes advising patients of their options in light of their medical condition optional for those who refuse on conscience grounds to "assist in" particular treatment.

83. Another section purports to allow providers and institutions to interpose religious or moral refusals to services beyond abortion and sterilization, the stated subjects of the Church Amendments, authorizing them to deny services

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to members of the LGBTQ community. *See* 42 U.S.C. § 300a-7 (entitled "Sterilization or abortion"). The Final Rule prohibits discrimination against a person assisting "in any lawful health service" who asserts a conscience-based objection, Final Rule § 88.3(a)(2)(v), and prohibits covered entities from requiring any objecting person to assist in the performance of "any part of a health service program." *Id.* § 88.3(a)(2)(vi).

b. "Discriminate" or "discrimination"

84. The Final Rule includes a definition for "discriminate" or "discrimination," which was previously undefined. HHS defines these terms to include (1) withholding, reducing, excluding, terminating, restricting, or otherwise making unavailable or denying any grant, contract, subcontract, cooperative agreement, loan, license, certification, accreditation, employment, title, or other similar instrument, position, status, benefit, or privilege or imposing any penalty; and (2) using any criterion, method of administration, or site selection (including the enactment, application, or enforcement of laws, regulations, policies, or procedures directly or through contractual or other arrangements) that subjects protected individuals or entities to any adverse treatment.

85. The Final Rule partially incorporates Title VII's approach to the reasonable accommodation of religion—but without the "undue hardship" exception. Entities will not have engaged in discrimination if they offer an

effective accommodation for the exercise of protected conduct, religious beliefs, or moral convictions (assuming that offer is voluntarily accepted). Employers can inform the public of the availability of alternate staff or methods but are not required to do so and cannot single out staff if doing so would be retaliatory.

86. Objecting employees can be required to disclose their objections to the employer if there is a reasonable likelihood that they would be asked to take this action.

c. "Entity" and "health care entity"

87. The Final Rule includes separate definitions for "entity" and "health care entity" and, in doing so, expands the application of federal conscience laws that refer to "entity." Under the predecessor rule, the definition for "entity" and "health care entity" had been identical, limiting application of federal conscience laws to health care entities (such as health care professionals).

88. The definition of "entity" has been broadened to include "persons" (individuals, corporations, companies, associations, firms, partnerships, societies, and joint stock companies), states, political subdivisions, state instrumentalities or political divisions, and any public agency, public institution, public organization, or other public entity.

89. Three of the statutes—the Weldon Amendment, the Coats-Snowe Amendment, and Section 1553 of the ACA—use the term "health care entity." For all three statutes, "health care entity" includes an individual physician or

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other health care professional (including a pharmacist); health care personnel; a participant in a health professions training program; an applicant for training or study in the health professions; a post-graduate physician training program; a hospital; a medical laboratory; an entity engaging in biomedical or behavioral research; a pharmacy; any other health care provider or facility; and (potentially) a component of state or local government. HHS added pharmacies and pharmacists in the Final Rule.

90. For purposes of the Weldon Amendment and Section 1553, a "health care entity" additionally includes provider sponsored-organizations, HMOs, issuers, group and individual health insurance plans, plan sponsors, and third-party administrators. The inclusion of plan sponsors in the definition applies to all employers that sponsor a group health plan even when they are not otherwise a "health care entity."

d. "Health service program"

91. The Final Rule eliminated the definition of "health program or activity" and refers only to "health service program." A health service program includes any health or health-related services or research activities, benefits, insurance coverage, studies, or any other service related to health or wellness. The definition includes programs provided or administered directly, through insurance, or through payments, grants, contracts, or other instruments.

e. "Referral" or "refer for"

92. The Final Rule defines "referral" or "refer for" to include providing information in oral, written, or electronic form (including names, addresses, phone numbers, email or web addresses, directions, instructions, descriptions, or other information resources) where the purpose or reasonably foreseeable outcome of providing that information is to assist a person in receiving funding or financing for, training in, obtaining, or performing a particular health care service, program, activity, or procedure.

93. Under this definition, an individual would not have to provide contact information of a physician or clinic that may provide an abortion, tell a patients that funding is available for abortion, or provide a phone number where they can be referred to abortion services or funding.

3. Assurance and certification

94. Under the Final Rule, every application for federal funding from HHS must include both an assurance and a certification that the applicant or recipient will comply with applicable federal conscience laws. Final Rule § 88.4(a).

4. Compliance and enforcement

95. HHS states that each recipient of HHS funds "has primary responsibility to ensure that it is in compliance with" the Final Rule. Final Rule § 88.6(a). Further, if HHS finds that a subrecipient of federal funds, such as a

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clinic included in a state's federally subsidized Title X network, violated the Final Rule, the state "may be subject to the imposition of funding restrictions or any appropriate remedies available under this part . . . ." *Id.*

96. OCR has discretion in choosing its means of enforcement, which could range from informal resolution to more rigorous enforcement. In response to a violation, OCR could terminate federal funds, withhold federal payments, withhold new federal funds, suspend award activities, refer a matter to the Department of Justice, or take other remedies.

5. Preemption

97. The Final Rule contains a provision that addresses preemption of state laws. Final Rule § 88.8. This provision states that it does *not* preempt only those state laws that are *equally or more protective of* religious freedom and moral convictions. In contrast, HHS purports to preempt state laws, such as those in Washington, that balance conscience objections with guarantees of patient access to care. "To the extent State or local standards or laws conflict with the Federal laws that are the subject of this rule, the Federal conscience and antidiscrimination laws preempt such laws and standards . . . ." 48 Fed. Reg. at 23266.

D. The Final Rule's Impact on Washington

1. Abrogation of Washington's laws protecting patients

98. Washington has a sovereign interest in its "power to create and enforce a legal code." *Alfred L. Snapp & Son, Inc. v. Puerto Rico ex rel. Barez*, 458 U.S. 592, 601 (1982); *see also Bowen v. Pub. Agencies Opposed to Soc. Sec. Entrapment*, 477 U.S. 41, 51 n.17 (1986) (there is "no question" that states have standing to sue to preserve their sovereignty where sovereign interests have been interfered with or diminished).

99. As reflected in numerous laws in Washington's legal code, the Washington legislature has carefully balanced the right of individuals and organization to refuse to provide health care services because of conscience objections with Washingtonians' rights "to receive the full range of services" covered under the state's health insurance plans." Wash. Rev. Code 48.43.065. These laws include the Reproductive Privacy Act, Wash. Rev. Code 9.02.100, *et seq*.; the Reproductive Parity Act, Wash. Rev. Code 48.43.072–.073; Washington's Informed Consent statute, Wash. Rev. Code 7.7.050; Washington's regulation governing pharmacies' responsibilities, Wash. Admin. Code 246-869-010; its statute mandating emergency contraception for sexual assault victims, Wash. Rev. Code 70.41.350; the duty to counsel on advanced directives, Wash. Rev. Code 70.122.060(2); the duty to transfer medical records of patients seeking end-of-life care, Wash. Rev. Code 70.245.190(d); the statute

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prohibiting health care-related discrimination based on gender identity, 2019 Wash. Sess. Laws, ch. 399, § 2(1); and Washington's charity care law prohibiting patient abandonment, among other laws. *See supra* at Section B.1.

100. The Final Rule purports to preempt these Washington laws, impeding Washington from enforcing its legal code. Under the Final Rule, HHS could argue that Washington is barred from taking action against a hospital that refused to provide emergency contraception to a victim of sexual assault. HHS could assert that the State is powerless to enforce its regulations ensuring that pharmacies fill a person's lawful prescription for contraception. It could impede the Attorney General from acting under state civil rights laws against health care providers who refused to provide medically indicated services to gay or transgender patients because they had a moral objection to them. Further, it could threaten Washington with the loss of over $10 billion in HHS funding if the State did not acquiesce, forcing it to choose between its civil rights laws and its Medicaid and children's health insurance programs.

2. Denied or delayed health care to Washingtonians

101. Washington has a quasi-sovereign interest in "ensuring that the State and its residents are not excluded from the benefits that are to flow from participation in the federal system." *Alfred L. Snapp & Son, Inc.*, 458 U.S. at 608. "[F]ederal statutes creating benefits . . . create interests that a State will obviously wish to have accrue to its residents." *Id.* Washington's quasi-sovereign interests

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include "the health and well-being—both physical and economic—of its residents in general," and "assuring the benefits of the federal system are not denied to its general population." *Id.* at 607–08.

102. The Final Rule will jeopardize the health of Washington residents and cause injury to patients seeking medically indicated reproductive care, sterilization, options counseling, emergency contraception, and other forms of health care. Washingtonians will be denied their guaranteed rights to prompt health care consistent with applicable medical and ethical standards because of conscience-based refusals. These refusals could come not only from medical professionals but from orderlies, cabulance drivers, appointment schedulers, or insurance company telephone representatives.

103. To illustrate the potential serious harm to Washington residents, consider a hypothetical patient in Skagit County with a high-risk pregnancy who regularly sees an OB/GYN high-risk specialist at the University of Washington. Her OB/GYN determines that she is miscarrying and, under applicable standards of care, she needs to be treated immediately to prevent infection, sepsis, and even death. Washington law would prevent a hospital faced with a patient in an emergency condition from refusing care and transferring the patient to a different institution. Under the Final Rule, however, the nearest hospital could refuse to admit her if it opposed pregnancy terminations on religious grounds, and it could force the woman to be transported to Seattle for care.

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104. As another illustration, consider an elderly resident of Benton County terminally ill with aggressive, stage four liver cancer, who seeks to avoid a painful end to his long life. He consults with a physician at the only healthcare system near his rural home and makes a request for life-ending medications consistent with the DWDA. Under the DWDA, a non-participating provider must inform the patient that it does not provide services under the DWDA, and it must transfer his records to a new health care provider. Under the Final Rule, however, the institution does not need to inform the patient that it declines to participate in the DWDA, and it could delay or refuse his request to transfer his records to a participating provider. The patient could experience an avoidable, painful death without ever learning that the facility does not participate in the DWDA.

105. Or, alternatively, consider a college student who is a victim of a violent sexual assault. She is transported to a hospital emergency room, and she requests the morning after pill. Washington law requires the hospital to immediately provide her emergency contraception. Under the Final Rule, however, the hospital may refuse to provide the medication because of a religious policy objecting to terminating pregnancies, and instead—against her wishes—it may counsel her on adoption or social services available to pregnant teens.

3. Impact on state health care institutions

106. "As a proprietor, [a state] is likely to have the same interests as other similarly situated proprietors . . . , [a]nd like other such proprietors it may at times

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need to pursue those interests in court." *Snapp*, 458 U.S. at 601–02. Washington operates numerous health care entities covered by the Final Rule. Consistent with state law and standards of medical ethics, Washington health care entities prioritize patient care and prohibit discrimination of care. By imposing an absolute duty on health care providers to accommodate the religious objections of any employee to providing any service to any patient—no matter the burden it imposes on the provider, other employees, or the patient—the Final Rule invites and sanctions discrimination against patients based on protected characteristics such as sexual orientation or gender identity.

4. Financial injury to Washington

107. "It is a bedrock proposition that 'a relatively small economic loss—even an identifiable trifle—is enough to confer standing.' " *Massachusetts v. U.S. Dep't of Health & Human Servs.*, No. 18-1514, 2019 WL 1950427, at *9 (1st Cir. May 2, 2019) (quoting *Katz v. Pershing, LLC*, 672 F.3d 64, 76 (1st Cir. 2012)). Washington faces far more than a small economic loss from the enforcement and penalty provisions of the Final Rule, which place at risk, alternatively, all "Federal financial assistance or other federal funds, in whole or in part," Final Rule § 88.7(i)(3)(i), or "Federal financial assistance or other federal funds from the Department [of Health and Human Services], in whole or in part," Final Rule § 88.7(i)(3)(ii), (iv), and (v).

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108. Based on information maintained by the Washington Office of Financial Management, in 2018 Washington received over $10.5 billion annually in financial assistance of other federal funds from HHS. The enforcement provisions of the Final Rule allow HHS to withhold, deny, suspend, or terminate billions of dollars in federal health care funds to Washington in HHS's discretion. According to publicly available information on HHS's Tracking Accountability in Government Grants System (TAGGS), Washington received over $8.9 billion in federal funding from HHS in the 2018 federal fiscal year for entities identified as being at the state level in the TAGGS system. The Final Rule threatens this funding should HHS determine, in its discretion, that Washington or any of it subrecipients is not complying with the Final Rule or any of the statutes it implements. Specifically, in fiscal year 2018, this money included:

a. $8.2 billion in funding for Washington's Medicaid and Children's Health Insurance Program.

b. Over $64 million in funding to the Washington Department of Health for a variety of programs and assistance including Title X, Medicare Entitlement for Washington Health, TB Elimination and Laboratory Cooperative Agreements, Universal Newborn Hearing Screening, Maternal and Child Health Services, Washington State Department of Health Integrated HIV Surveillance and Prevention Programs, Hospital Preparedness Programs, and many others.

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c. Over $108 million in funding to the Washington Health Care Authority for a variety of programs including Block Grants for Mental Health Services, Substance Abuse Prevention and Treatment Block Grants, Opioid Response Grants, and many others.

d. Several million dollars in funding to the Washington Department of Social and Health Services for a variety of programs including Refugee Cash and Medical Assistance, Refugee Social Services, employment services to individuals suffering severe mental illness and co-occurring substance disorders through the Becoming Employed Starts Today program, and many others.

109. In addition to the denial of federal funds, the Final Rule will impose other direct costs on Washington. The Final Rule gives HHS authority to financially penalize Washington if a subrecipient of federal funds violates the Final Rule. Final Rule § 88.6(a). As a result, Washington will be required to expend added funds, staffing, and other resources to review and monitor subrecipients' policies, compliance, and complaints regarding refusal rights. For example, the Washington Department of Health (DOH) administers and co-funds with HHS a family planning program comprised of eighty-five clinics providing free or low-cost contraceptives and other reproductive health services to low-income people in thirty-two of Washington's thirty-nine counties. This network of clinics is operated by subrecipients that DOH compensates in part

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with funds from HHS's Title X grant to the State. The Final Rule will require DOH's Family Planning Program to expend additional staff, resources, and funds on monitoring and ensuring compliance with the absolute refusal rights the Final Rule purports to create for its Title X family planning provider subgrantees.

V. CLAIMS FOR RELIEF

Count I
Violation of the Administrative Procedure Act
Agency Action Not in Accordance with Law—Claimed HHS Authority

110. Washington realleges and reincorporates by reference the allegations set forth in each of the preceding paragraphs.

111. The APA requires that agency action that is "not in accordance with law" be held unlawful and set aside. 5 U.S.C. § 706(2).

112. The Final Rule violates the statutes HHS purports to interpret by adopting constructions of them not intended or authorized by Congress. HHS's unlawfully broad interpretations of these statutes include making the refusal rights of individuals and institutions absolute and categorical; broadly allowing providers to refuse to engage in health care counseling; applying its provisions not just to health care professionals but to any employee; applying its provisions to non-health care providers such as insurance companies and non-health employers; and imposing on Washington the responsibility to police the compliance with the rule of its subrecipients of federal funds.

113. In addition, the Final Rule purports to create a mechanism that would allow HHS to impose financial penalties on Washington unauthorized by

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the statutes HHS invokes. The Final Rule's enforcement scheme would permit HHS to withhold or deny Washington federal funding amounting to billions of dollars if OCR determines that it or one of its subrecipients failed to comply with the Final Rule.

114. Absent injunctive and declaratory relief vacating the Final Rule and prohibiting it from going into effect, Washington and its residents will be immediately, continuously, and irreparably harmed by Defendants' illegal actions.

Count II
Violation of the Administrative Procedure Act
Agency Action Not in Accordance with Law—Other Federal Laws

115. The State realleges and reincorporates by reference the allegations set forth in each of the preceding paragraphs.

116. The APA requires that agency action that is "not in accordance with law" be held unlawful and set aside. 5 U.S.C. § 706(2).

117. Section 1554 of the ACA provides that the HHS Secretary "shall not promulgate any regulation" that "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care"; "impedes timely access to health care services"; "interferes with communications regarding a full range of treatment options between the patient and the provider"; "restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions"; or "violates the principles of informed

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consent and the ethical standards of health care professionals." 42 U.S.C. § 18114.

118. The Final Rule violates Section 1554 in numerous ways, including, among other ways, by creating "unreasonable barriers to the ability of individuals to obtain appropriate medical care" through the denial of counseling and referrals and sanctioning delays and denials of medically indicated care; "impeding timely access to health care services" by permitting delays in and denials of care required by applicable medical standards; "interfer[ing] with communications regarding a full range of treatment options between the patient and the provider" by unlawfully authorizing the denial of counseling and referrals; "restrict[ing] the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions"; and "violat[ing] the principles of informed consent and the ethical standards of health care professionals" by permitting medical professionals to withhold medically relevant information and violate medical ethical standards and other duties to their patients recognized by leading medical authorities. 42 U.S.C. § 18114.

119. The Final Rule violates the contraceptive coverage requirement in the ACA, 42 U.S.C. § 300gg-13(a)(4), with regard to non-exempt employers with religious beliefs that conflict with the use of contraceptives, by creating an absolute refusal right that conflicts with the accommodation created by HHS's own regulations.

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120. The Final Rule violates EMTALA by allowing hospitals to assert a categorical objection to providing patients requiring certain services with a medical screening examination and, if the patient has an "emergency medical condition," stabilizing treatment or providing an appropriate transfer. 42 U.S.C. § 1395dd; 42 C.F.R § 489.24.

121. The Final Rule violates the Non-Directive Mandate in annual appropriations acts applicable to HHS requiring that all pregnancy counseling within a Title X program be nondirective. *See* Pub. L. No. 115-245 (Sept. 28, 2018). The Final Rule violates the Non-Directive Mandate by purporting to permit objecting providers in Washington to refuse to ensure that patients determined to be pregnant receive information on all available options without promoting, advocating, or encouraging one option over another.

122. The Final Rule violates Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e(j), by eliminating the "undue hardship" exception for employers who are required to accommodate employees' religious beliefs and avoid discrimination in employment based on religion.

123. Absent injunctive and declaratory relief vacating the Final Rule and prohibiting it from going into effect, Washington and its residents will be immediately, continuously, and irreparably harmed by Defendants' illegal actions.

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Count III
Violation of the Administrative Procedure Act
Arbitrary and Capricious Agency Action

124. The State realleges and reincorporates by reference the allegations set forth in each of the preceding paragraphs.

125. The Final Rule is arbitrary and capricious in numerous respects. It reverses the Department's longstanding policies and interpretations of Title X with no evidentiary basis or cogent rationale, requires deviation from evidence-backed standards of care and medical ethical and fiduciary obligations, needlessly jeopardizes patients' lives, health, and well-being, disregards and/or is contrary to evidence before the agency, ignores many important aspects of the problem and the significant new problems it will create, relies on factors Congress did not intend the agency to consider, and is illogical and counterproductive.

126. One or more of these problems affects virtually every new provision of the Final Rule, rendering the Final Rule arbitrary and capricious in its entirety.

127. Absent injunctive and declaratory relief vacating the Final Rule and prohibiting it from going into effect, Washington and its residents will be immediately, continuously, and irreparably harmed by Defendants' illegal actions.

Count IV
Violation of the Spending Clause

128. The State realleges and reincorporates by reference the allegations set forth in each of the preceding paragraphs.

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129. Article I, section 8, clause 1 of the United States Constitution, also known as the Spending Clause, states that "Congress shall have power to lay and collect taxes, duties, imposts and excises, to pay the debts and provide for the common defense and general welfare of the United States."

130. The Final Rule violates the Spending Clause because the restrictions are unconstitutionally coercive, do not provide the State with adequate notice of what action or conduct will result in a withholding of federal health care funds, and impose sanctions that are not rationally related to the underlying federal programs.

131. When conditions on the payment to state or local governments of specific federal funds "take the form of threats to terminate other significant independent grants, the conditions are properly viewed as a means of pressuring the States to accept policy changes." *Nat'l Fed. of Indep. Bus. v. Sebelius*, 567 U.S. 519, 580 (2012). Here, the Final Rule threatens to terminate or withhold billions of dollars of healthcare federal funding that the State would otherwise receive, and in so doing, imposes conditions that "cross[] the line distinguishing encouragement from coercion." *Id.* at 579. The Department's threat to withhold or deny billions of dollars of healthcare funds, including funds unrelated to healthcare, is "much more than 'relatively mild encouragement'—it is a gun to the head." *Id.* at 581. A threat of this magnitude leaves the State "with no real option but to acquiesce" to the federal requirement. *Id.* at 582.

132. If Congress intends to condition a State's receipt of federal funds, it must do so unambiguously so that the State can exercise its choice knowingly and voluntarily. *South Dakota v. Dole*, 483 U.S. 203, 207 (1987). Among other things, the Final Rule uses terms that are vague, defines terms inconsistently with the underlying federal statutes or long-standing usage, imposes new conditions on the receipt of federal funds, and does not adequately describe the actions that will lead to sanctions. The Final Rule is ambiguous and therefore unconstitutional.

133. Federal funding conditions must also be rationally related to the federal interest in the particular program that receives federal funds. The Final Rule is unconstitutional under the Spending Clause because it places conditions on the receipt of federal funds that are not "[]related to the federal interest in particular national projects or programs" paid for by those funds. *Id.* at 207.

134. Absent injunctive and declaratory relief vacating the Final Rule and prohibiting it from going into effect, Washington and its residents will be immediately, continuously, and irreparably harmed by Defendants' illegal actions.

Count VI
Separation of Powers

135. The State realleges and reincorporates by reference the allegations set forth in each of the preceding paragraphs.

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136. The United States Constitution exclusively grants the spending power to Congress. U.S. Const. art. 1, § 8, cl. 1. Congress may delegate some discretion to the Executive Branch, but the Executive Branch is not allowed to amend or cancel Congressional appropriations.

137. The Final Rule permits Defendants to refuse to disburse money appropriated by Congress, thereby violating constitutional separation of powers principles.

138. Absent injunctive and declaratory relief vacating the Final Rule and prohibiting it from going into effect, Washington and its residents will be immediately, continuously, and irreparably harmed by Defendants' illegal actions.

Count VII
Violation of the Establishment Clause

139. The State realleges and reincorporates by reference the allegations set forth in each of the preceding paragraphs.

140. Under the Establishment Clause of the First Amendment, the "[g]overnment in our democracy, state and national, must be neutral in matters of religio[n]." *Epperson v. Arkansas*, 393 U.S. 97, 103 (1968). The government "may not aid, foster, or promote one religion or religious theory against another," *id.*, nor "religion over irreligion," *McCreary Cty. v. ACLU of Kentucky*, 545 U.S. 844, 875 (2005). "When the government acts with the ostensible and predominant purpose of advancing religion, it violates that central Establishment

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Clause value of official religious neutrality . . . .” *Id.* at 860. The government also violates the Establishment Clause where it imposes an “absolute duty” on employers to “conform their business practices to the particular religious practices of [an] employee,” such that “religious concerns automatically control over all secular interests at the workplace.” *Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 709 (1985).

141. The Final Rule has the predominant purpose and effect of advancing, endorsing, and elevating individual health care workers’ religious beliefs above all other interests—including patients’ health, welfare, and choices (whether religious or secular). In doing so, the Final Rule imposes an absolute duty on medical providers—including state-operated entities—to accommodate employees’ asserted religious beliefs no matter what burdens doing so would impose on the providers, other employees, or patients. In promulgating the Final Rule, HHS has put its thumb on the scale to favor some religious beliefs over other beliefs, telling “nonadherents ‘that they are outsiders, not full members of the political community, and . . . adherents that they are insiders, favored members of the political community.’” *Santa Fe Indep. Sch. Dist. v. Doe*, 530 U.S. 290, 309–10 (2000).

142. The Final Rule violates the Establishment Clause, causing harm to Washington’s sovereign and proprietary interests, and to its residents.

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VI. PRAYER FOR RELIEF

Wherefore, the State of Washington prays that the Court:

a. Declare that the Final Rule is unauthorized by and contrary to the Constitution and laws of the United States;

b. Declare that the Final Rule is invalid and without force of law and vacate the Final Rule in full;

c. Issue preliminary and permanent injunctions prohibiting Defendants from implementing or enforcing the Final Rule;

d. Award the State of Washington its costs and reasonable attorneys' fees; and

e. Award such other and further relief as the interests of justice may require.

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RESPECTFULLY SUBMITTED this 28th day of May 2019.

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