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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

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-SAB

PLAINTIFF'S REPLY IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT

NOTED FOR: November 7, 2019
With Oral Argument at 10:00 AM
Location: Spokane, Washington

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I. INTRODUCTION

Lacking congressional authority to interpret the statutes that the Rule purports to implement, HHS used a fabricated administrative record to issue a Rule creating newly minted rights that threatens to disrupt the medical system and patient care. This Rule cannot withstand scrutiny under the Administrative Procedure Act (APA) and must be set aside.

The Underlying Statutes. HHS stumbles at the outset because it is unable to identify any source within the Church, Coats-Snowe, or Weldon Amendments for the authority to make rules with the force of law. It therefore is forced to argue that its Rule actually does very little: "far from being a sea change, the Rule merely implements and clarifies important preexisting conscience protections enacted by Congress." ECF No. 64 at 1; ECF No. 44 at 3 (asserting that the Rule "simply clarifies HHS's enforcement process"). But, as reflected by President Trump's own announcement of the Rule as establishing "*new protections* of conscience rights for physicians, pharmacists, nurses, teachers, students, and faith-based charities," this veneer is wrong. Indeed, the Rule redefines four statutory terms to create the "new protections" the President announced:

- It redefines "discrimination" to give health care employees an absolute right to refuse an offer of a reasonable accommodation and leaves the employer with no recourse, regardless of the hardship it imposes on the employer's ability to provide care to patients;
- It redefines the term "assist in the performance" in the Church Amendments to include individuals entirely uninvolved in the

performance of an actual procedure, such as a scheduler, receptionist, or ambulance driver;

- It jettisons the accepted medical definition of "referral" and redefines it to include the giving of any information where a "foreseeable outcome" is to assist a person in receiving an objected-to service—so, for example, an insurance representative could refuse to give information or answer questions on whether abortion is a covered service;

- It expands the definition of "health care entity" beyond the subjects covered by the Amendments it purports to implement—so, for example, a law focusing on training and licensing of physicians now extends to pharmacies and medical labs.

HHS's Decision-Making. HHS next devotes a substantial portion of its opposition to touting its "reasoned decision-making." ECF No. 64 at 18. But it does not dispute that the Administrative Record revealed a critical justification for the Rule to be fabricated. Of the over 300 administrative complaints it highlighted as warranting new "enforcement tools," 84 Fed. Reg. 23170, 23175 (May 21, 2019) ("Reasons for the Final Rule"), *only 6%* relate to the laws that were the subject of the Rule. Because a crucial factual premise of the Rule has been shown by the agency's records to be indisputably incorrect, HHS's rulemaking must be set aside under the APA.

HHS's Consideration of Harm. HHS contends that it "thoroughly considered the issues raised in the comments" and "supported each challenged aspect of the Rule with sound and detailed reasoning." ECF No. 64 at 2, 18. But nowhere in the Rule does HHS address the alarming concerns raised by such entities as the AMA and the American College of Emergency Physicians. While

1 the Rule concedes that "[m]any comments the Department received argued that
2 the rule would decrease access to care and harm patient health outcomes," 84
3 Fed. Reg. at 23250, instead of providing "thoughtful explanations in response,"
4 the agency simply dismissed those concerns based on its determination that there
5 was no data from which it could make a "reliable quantification of the effect of
6 the rule on access to providers and to care." *Id.* But as the Amicus Brief of
7 Leading Medical Organizations makes clear, "the Rule will radically disrupt
8 medical care and *endanger the lives and health of patients*." ECF No. 63-1 at 4–
9 5 (emphasis added). Reasonable rulemaking cannot ignore such significant
10 concerns.

11 For these and the other reasons presented by Washington here and in its
12 opening brief, the Rule should be vacated in its entirety.

13 **II. ARGUMENT**

14 **A. The Rule Violates the Administrative Procedure Act**

15 **1. Congress did not delegate to HHS authority to interpret the**
16 **Church, Coats-Snowe, or Weldon Amendments**

17 In its motion for summary judgment, Washington explained that Congress
18 did not delegate authority to HHS to issue rules interpreting the Church, Coats-
19 Snowe, or Weldon Amendments, making the Rule "beyond the *Chevron* pale."
20 *United States v. Mead Corp.*, 533 U.S. 218, 234 (2001); *Gonzales v. Oregon*, 546
21 U.S. 243, 255–56 (2006). *Chevron* only applies "when it appears that Congress
22 delegated authority to the agency generally to make rules carrying the force of

law, and . . . the agency interpretation claiming deference was promulgated in the exercise of that authority." *Mead Corp.*, 533 U.S. at 226–27. Neither of these requirements is satisfied here. As a result, HHS's Rule is invalid because it exceeds HHS's statutory authority and, at a minimum, is entitled to no deference.

a. Washington has not waived its challenge to HHS's statutory authority

In an attempt to sidestep this argument, HHS contends that "Plaintiff *conceded* HHS's authority to interpret these statutes" based on a single sentence in Washington's preliminary injunction motion. ECF No. 64 at 2. This assertion is groundless. "A party is not required to prove her case in full on preliminary injunction, but only such portions as will enable her to obtain the injunction." *Arce v. Douglas*, 793 F.3d 968, 976 (9th Cir. 2015). Thus, Washington is not limited to the arguments raised in its motion for preliminary injunction. *See, e.g.*, *Univ. of Tex. v. Camenisch*, 451 U.S. 390, 396 (1981).

In a further attempt to avoid review by this Court, HHS next argues that Washington failed to specifically allege in its Complaint that HHS lacks authority to interpret the Church, Coats-Snowe, and Weldon Amendments. ECF No. 64 at 3. But this argument is also wrong. Washington's Complaint amply put HHS on notice of its claim that the agency was acting without statutory authority. *See* ECF No. 1 at Count I ("Violation of Administrative Procedure Act— . . . Claimed HHS Authority"), ¶¶ 111–13. Because this threshold legal issue is now fully

briefed, it is ripe for determination by the Court.[1]

b. HHS lacks explicit authority

Rather than cite to explicit terms of the Church, Coats-Snowe, and Weldon Amendments that provide authority for the Rule, HHS contends that "various housekeeping and other statutes" allow it to promulgate rules that "correspond to or supplement" other regulations (i.e., the Uniform Administrative Requirements (UAR)), and that these supplemental HHS regulations authorize the Rule. *See* ECF No. 64 at 4. It also points to several other statutes that it contends "explicitly authorize HHS to issue the Rule." *Id.* at 3. These arguments fail for several reasons.

First, HHS, as an agency, cannot grant itself, through its own regulations, the power to promulgate legislative rules interpreting and enforcing the conscience laws. "[T]he exercise of quasi-legislative authority by governmental . . . agencies must be rooted in a grant of such power by the Congress." *Chrysler Corp. v. Brown*, 441 U.S. 281, 302 (1979).

Second, HHS may not use its housekeeping authority as "an authorization for the promulgation of substantive rules." *United States ex rel. O'Keefe v. McDonnell Douglas Corp.*, 132 F.3d 1252, 1255 (8th Cir. 1998); *see Chrysler*

[1] To the extent the Court determines that Washington's Complaint lacks sufficient detail on this purely legal issue, Plaintiff respectfully asks the Court for leave to amend its Complaint.

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Corp., 441 U.S. at 309–10.

Third, HHS contends that several other statutory provisions (42 U.S.C. §§ 1302, 18023, 18113, 18041, 263a, & 1315a) directly grant it authority to promulgate the Rule. ECF No. 64 at 4–5. But none of these statutes grant HHS rulemaking authority concerning the Church, Coats-Snowe, and Weldon Amendments. *See, e.g.*, 42 U.S.C. § 1302 (requirement that the Secretary of the Treasury, Secretary of Labor, and Secretary of HHS make and publish rules and regulations under the chapter on impact analyses of Medicare and Medicaid rules and their potential effects on small rural hospitals); *id.* § 18041 (Affordable Care Act's (ACA) provisions requiring HHS to issue regulations setting standards for the establishment and operation of healthcare exchanges); *id.* § 18113 (ACA's designation of HHS to receive complaints of discrimination against healthcare entities related to end-of-life care). Because none of these statutes delegate HHS authority to promulgate regulations as to the Church, Coats-Snowe, and Weldon Amendments, this argument fails too.

c. HHS lacks implicit authority

Having failed to identify any express delegation of authority to promulgate the Rule, HHS tries to conjure its authority implicitly from the "Federal Conscience Statutes." ECF No. 64 at 6. But it is not "apparent from the agency's generally conferred authority and other statutory circumstances that Congress would expect the agency to be able to speak with the force of law when it

addresses" the conscience laws in a way that affects multiple agencies. *Mead Corp.*, 533 U.S. at 229. As Washington has explained throughout its briefing, Congress could not have impliedly granted HHS such broad rulemaking authority as this harsh Rule.

Citing *Barnhart v. Walton*, 535 U.S. 212 (2002), HHS lists several factors that it says courts consider "[t]o determine whether Congress has implicitly delegated authority," and argues that those factors weigh in its favor. ECF No. 64 at 6–7. But HHS distorts *Barnhart*.

In *Barnhart*, HHS undisputedly was "[a]cting pursuant to statutory rulemaking authority" in "promulgat[ing] formal regulations." 535 U.S. at 217. Thus, the Court was not deciding "whether Congress ha[d] implicitly granted authority" to the agency, as HHS states. ECF No. 64 at 6–7. Instead, the Court was considering whether the agency's interpretation of its formal regulations was entitled to *Chevron* step two deference. 535 U.S. at 218–19. And it was on that issue—whether to defer to the agency's rulemaking—that the Court looked to the factors cited by HHS. *Id.* at 219–22.

Here, by contrast, there is no dispute that HHS lacks explicit statutory rulemaking authority under the Church, Coats-Snowe, and Weldon Amendments. Thus the *Barnhart* factors are inapplicable here.[2]

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[2] Even if the *Barnhart* factors applied, they would not support an implicit delegation. HHS itself argues that the definitions are clear (ECF No. 44 at 27,

Indeed, the fact that HHS *enforces* the Church, Coats-Snowe, and Weldon Amendments does not automatically translate to interpretive authority. *See* ECF No. 64 at 4, 7. An express delegation of rulemaking authority signals that a rule "merit[s] *Chevron* treatment," *Mead Corp.*, 533 U.S. at 229–30, but that is different from a delegation of enforcement authority. Indeed, the Supreme Court has declined to grant *Chevron* deference to the EEOC's interpretations of Title VII for this reason notwithstanding its "responsibility for enforcing Title VII" of the Civil Rights Act. *EEOC v. Arabian Am. Oil Co.*, 499 U.S. 244, 257 (1991); *see Mead Corp.*, 533 U.S. at 229–30.

For these reasons, HHS lacks authority to issue the Rule, and its claims to *Chevron* deference should be rejected.

d. HHS's expanded enforcement authority is unauthorized

HHS does not directly respond to Washington's argument that it created draconian new enforcement powers not authorized by Congress. Instead, it attempts to downplay the Rule's new enforcement scheme, explaining coolly that "[t]he Rule simply makes explicit that, under longstanding, unchallenged HHS UAR and HHSAR procedures, recipients of HHS funds must comply with the Federal Conscience Statutes and may face certain consequences if they do not."

29–30, 32–33, 34–36), so it cannot plausibly contend that the definitions are "interstitial." Nor are the definitions necessary to the administration of the conscience laws, which were implemented for decades without the Rule.

ECF No. 64 at 5. It further states that "the Rule follows the HHS UAR *to the letter*." *Id.* at 6 (emphasis in HHS brief).

But as Washington previously explained, the enforcement mechanisms set forth in the Rule are not so circumscribed. ECF No. 57 at 9–10. Indeed, the Rule plainly sets forth new remedies for noncompliance that do not exist in the UAR.

For example, while the UAR allows the agency to "terminate *the* Federal award" at issue or "[w]ithhold further Federal awards *for the project or program*," 45 C.F.R. §§ 75.371(c), (e) (emphases added), the Rule speaks in much broader terms. Specifically, it provides for "[t]emporarily withholding Federal financial assistance or other federal funds, in whole or in part"; "[d]enying use of Federal financial assistance or other Federal funds from the Department . . . in whole or in part"; "[t]erminating Federal financial assistance or other Federal funds from the Department, in whole or part"; and "[d]enying or withholding, in whole or in part, new Federal financial assistance or other Federal funds from the Department administered by or through the Secretary . . . . " 84 Fed. Reg. at 23271–72 (§ 88.7(i)(3)(iv), (v)). Other differences between the Rule and the UAR abound. *See, e.g.*, *id.* at 23180 (permitting "funding claw backs," an extreme remedy not available under the UAR); *id.* at 23270 (§ 88.6(a)) (permitting recipient to be penalized for a violation by a sub-recipient, whereas the UAR only imposes monitoring responsibilities (45 C.F.R. § 75.352)).

Because HHS cannot point to any delegation of authority for the broad new

enforcement power it assumes under the Rule's plain language, the Rule exceeds HHS's statutory authority and must be set aside. *See Atl. City Elec. Co. v. FERC*, 295 F.3d 1, 9 (D.C. Cir. 2002).[3]

2. The Rule's definitions of statutory terms exceed HHS's statutory authority and are contrary to law

HHS violated the APA by adopting statutory definitions that go far beyond the bounds of the federal statutes that it purports to implement.

a. "Health care entity"

The Coats-Snowe and Weldon Amendments use the term "health care entity" to refer to discrete—and different—categories of individuals and entities, yet the Rule whitewashes these differences.[4] To gloss over these differences,

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[3] To be clear, Washington is only challenging the Rule's new enforcement scheme; it does not contest HHS's enforcement authority under the 2011 Rule.

[4] *See, e.g.*, 42 U.S.C. § 238n(c)(2) (Coats-Snowe Amendment: legislating on "[a]bortion-related discrimination in governmental activities regarding *training and licensing of physicians*"; stating that "[t]he term 'health care entity' includes an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions"); Pub. L. No. 115-245, 132 Stat. 2981, 3118 § 507(d)(1)–(2), (2018) (Weldon Amendment: protecting "any institutional or individual healthcare entity [from] discrimination on the basis that the health care entity does not provide, pay for, provide coverage

HHS doubles-down on its argument that the statutes' use of the term "includes" allows it to dramatically expand the class of individuals to whom the statutes apply. Not so.

HHS principally looks to a footnote in *Samatar v. Yousuf*, 560 U.S. 305 (2010) to support its position, but its reliance is misplaced. ECF No. 64 at 12. As the Supreme Court explained in *Samatar*, "[i]t is true that use of the word 'include' *can signal* that the list that follows is meant to be illustrative rather than exhaustive." 560 U.S. at 317 (emphasis added). But that is not the end of the inquiry; the use of the term "includes" does not turn the statutes into a free-for-all. *See Gutierrez v. Ada*, 528 U.S. 250, 255 (2000) ("words and people are known by their companions"). In *Samatar*, for instance, the Supreme Court used the statute's "textual clues" and "[o]ther provisions of the statute" to determine that Congress did not intend for the term "foreign state" to include officials. HHS's response, however, provides no such analysis. 560 U.S. at 317–18.

With respect to the Coats-Snowe Amendment, HHS provides *no* explanation as to why Congress intended a statute focused on "the training and licensing of physicians" to include the wide range of individuals, entities, and

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of, or refer for abortions"; defining health care entity to "include[] an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan").

facilities listed in its definition. *See* ECF No. 64 at 12–13. HHS unlawfully expands the amendment to apply to, for example, pharmacies, medical laboratories, and entities engaged in biomedical or behavioral research. 84 Fed. Reg. at 23264 (§ 88.2).

While HHS does proffer an explanation as to why it included plan sponsors and third-party administrators under the Weldon Amendment, the Rule's explanation make no sense. ECF No. 64 at 13. The "catch-all phrase" upon which HHS relies—i.e., that "health care entity" includes "any other kind of ***health care*** facility, organization, or plan"—cannot logically be read to encompass entities like employers who have no relation to "*health care*," other than simply providing employee benefits. *Id.*

HHS's attempt to use the word "include" in Coats-Snowe and Weldon to dramatically expand the definition of health care entity should be rejected.

b. "Assist in the performance"

In an effort to save its overbroad definition of "assist in performance," HHS misconstrues Washington's argument. Washington does not contend that the Church Amendments "are limited to 'the actual performance of an abortion or sterilization procedure." ECF No. 64 at 10. Instead, as Washington stated in its opening brief, "[t]he Church Amendments address '[s]terilization [and] abortion' and protect individuals and entities from being compelled 'to perform *or assist in the performance* of any sterilization procedure or abortion.' " ECF

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No. 57 at 15 (emphasis added). But Washington also made clear that "the statutory language of the Amendments is limited to individuals 'performing' or 'assisting' in the performance of the actual procedures"—not to any individual who takes an action connected to a procedure that may or may not be performed. *Id.* at 17.

This is why HHS's reliance on dictionary definitions fails. Washington does not dispute that "assist" means to give "supplementary support or aid to" and "performance" means "execution of an action." ECF No. 44 at 27. But the Rule's definition goes far beyond this plain language. Indeed, the Rule now includes individuals and actions that do not "support or aid" the "execution" of an abortion or sterilization—*e.g.*, a receptionist scheduling medical procedures or an ambulance driver transporting an individual to the hospital. *See* 84 Fed. Reg. at 23186–87, 23188. Thus, the plain language of Congress cannot be reconciled with the definition adopted by HHS.

As Washington previously explained, the Amendments' statutory history also confirms the overbreadth of HHS's Rule. *See* ECF No. 57 at 15–16. While HHS attempts to minimize the context in which Congress was legislating when it drafted the Church Amendments, it is "a fundamental canon that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme." *Wilderness Soc'y v. U.S. Fish & Wildlife Serv.*, 353 F.3d 1051, 1060 (9th Cir. 2003) (citation omitted). Moreover, "the structure and purpose of

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a statute may also provide guidance in determining the plain meaning of its provisions." *Id.* at 1060–61 (citing cases) (considering both dictionary definitions and "the purposes of the" statute it was interpreting). Thus, both the Church Amendment's history and its purpose are relevant to this Court's evaluation of the statutory language and confirm that HHS has dramatically and unreasonably expanded the statute's reach through its definition of "assist in the performance."

c. "Referral or refer for"

HHS's attempt to rehabilitate its overbroad definition of "referral or refer for" fares no better. As Washington explained in its opening brief, "referral" has an accepted meaning in the medical field: a provider directing a patient to another provider for care. ECF No. 57 at 18–19. HHS, however, stubbornly clings to its generic dictionary definition arguing that "the Ninth Circuit [ordinarily] consults *Merriam-Webster* at *Chevron* step one." ECF No. 64 at 14 (citing *Lagandaon v. Ashcroft*, 383 F.3d 983, 988 (9th Cir. 2004)).[5] But as Washington previously explained, even *Merriam-Webster* contains a "[m]edical [d]efinition of referral": "the process of directing or redirecting (as a medical case or a patient) to an

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[5] In *Langandaon*, the Ninth Circuit consulted Merriam-Webster along with two other dictionaries for the definition of "when." 383 F.3d at 988 and n.5. Elsewhere in the decision, the court looked to Black's Law Dictionary for the meaning of a "year." *Id.* at 991. That decision in no way circumscribes consultation with legal or medical dictionaries.

1 appropriate specialist or agency for definitive treatment." *See* ECF No. 57 at 19
2 n.7; *see also* Merriam-Webster's Medical Dictionary, https://www.merriam-
3 webster.com/dictionary/refer#medicalDictionary (last visited Oct. 17, 2019)
4 (defining "refer" as "to send or direct for diagnosis or treatment").
5 HHS does not (because it cannot) offer any reason that the common
6 medical definitions of referral and refer should not be applied to these statutes,
7 which were directed at physicians and health care entities. *See, e.g.*, 42 U.S.C.
8 § 238n (Coats-Snowe Amendment) (addressing "training and licensing of
9 physicians"); Pub. L. No. 111-117 § 508(d)(1), 123 Stat. 3034 (2009) (Weldon
10 Amendment) (protecting "any institutional or individual health care entity [from]
11 discrimination on the basis that the health care entity does not provide, pay for,
12 provide coverage of, or *refer for abortions*").
13 Applying the medical definition of "referral" to statutes directed at health
14 care entities is also consistent with "the rule of construction that technical terms
15 of art should be interpreted by reference to the trade or industry to which they
16 apply." *La. Pub. Serv. Comm'n v. FCC*, 476 U.S. 355, 372 (1986); *e.g.*, *Sullivan*
17 *v. Stroop*, 496 U.S. 478, 483 (1990) (using Black's Law Dictionary to define
18 child support because it was a "term of art"); *Chamber of Commerce v. Dep't of*
19 *Labor*, 885 F.3d 360 (5th Cir. 2018) (rejecting dictionary definition where the
20 words Congress used were terms of art in the financial industry).
21 Finally, while HHS contends that it is "irrelevant" that its non-medical
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1 definition would lead to "unreasonable results," ECF No. 64 at 14, this simply
2 underscores the absurdity of HHS's decision to use a non-medical definition of
3 refer or referral and the importance of using the common medical definition of
4 the term in interpreting these statutes aimed at the medical community.

5 **d. "Discriminate or discrimination"**

6 HHS offers no response to Washington's argument that the Rule's
7 definition of discrimination—which forces employers to sacrifice their business
8 needs to employees' absolute right to reject a reasonable accommodation—"far
9 exceeds the common legal definition of discrimination in federal case law." ECF
10 No. 57 at 20–21 (citing sources). Nor does it address the case law cited by
11 Washington holding that, under the Weldon Amendment, it would be
12 " 'anomalous' to "equate [job] reassignment with discrimination." *Id.* at 21
13 (quoting *Nat'l Family Planning & Reprod. Health Ass'n, Inc. (NFPRHA) v.*
14 *Gonzales*, 468 F.3d 826, 829–30 (D.C. Cir. 2006)). It further fails to address the
15 serious Establishment Clause issues that its definition would create. *Id.* at 22.

16 Instead, HHS now contends that the definition of discrimination is not a
17 definition at all, but is a "non-exhaustive list of what *may* constitute
18 discrimination." ECF No. 64 at 11. But the claim that the definitions in
19 subsections (1)–(3) under the term "Discriminate or Discrimination" (§ 88.2) are
20 somehow optional for regulated parties is completely fictional. It is not supported
21 by the language of the new regulation, and the preamble affirmatively rebuts this
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reading. *See* 84 Fed. Reg. at 23190 (stating that descriptions of prohibited behavior are "non-exclusive," not that they are optional).

Indeed, a review of the Rule makes clear that HHS's definition of "discrimination" is far more extreme than its brief implies. Specifically, after subsections (1) to (3) of the definition provide a robust and "non-exhaustive" list of what "[d]iscriminate or discrimination includes," *id.* at 23263, subsection (4) provides just a limited exception. The exception applies "where the entity offers *and the protected entity voluntarily accepts* an effective accommodation . . . ." *Id.* (emphasis added). Putting these subsections together, the Rule gives an employee an absolute right to refuse an offered accommodation (no matter how reasonable) and leaves the health care employer with no recourse, regardless of the hardship that it imposes on the employer's ability to provide care to its patients. *See id.* at 23191 (declining to "incorporate[e] the additional concept of an 'undue hardship' exception for reasonable accommodations under Title VII").

Under *Mead* or *Chevron*, this interpretation cannot be sustained. HHS's unprecedented expansion of "discrimination" in a manner that is inconsistent with the entire body of law that employers have relied upon to assess claims of religious discrimination finds no support in the language of Church, Coats-Snowe, or Weldon. Moreover, history and context also undermine HHS's interpretation. In a 1972 amendment to Title VII, Congress specified that an employer must "reasonably accommodate" an employee's religious practices—

unless doing so would impose an undue hardship on the conduct of the employer's business. 42 U.S.C. § 2000e(j); *see Trans World Airlines, Inc. v. Hardison*, 432 U.S. 63, 73–74 (1977). The very next year Congress passed Church, and this provision remained as subsequent Congresses enacted Coats-Snowe and Weldon. HHS's revision of the law of discrimination cannot be squared with this history or its prior policy.[6]

3. The Rule conflicts with existing healthcare laws in violation of the APA

a. The Rule conflicts with EMTALA

As Washington previously established, the Rule – through its overly broad definitions—creates an irreconcilable conflict with EMTALA, which prohibits hospitals from denying emergency medical care to patients with emergency medical conditions. In support of its position, Washington cited to numerous comments in the Administrative Record on this issue, which warn about, among

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[6] In its 2008 rulemaking, HHS determined that a definition of "discrimination" was not necessary. It explained that "[t]he term 'discrimination' is widely understood, and significant federal case law exists to aid entities in knowing what types of actions do or do not constitute unlawful discrimination." 73 Fed. Reg. 78072, 78077 (Dec. 19, 2008). HHS jettisoned this previous position without acknowledgement, let alone a "detailed justification." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009).

other things, "danger to patients' health, particularly in emergencies involving miscarriage management or abortion." ECF No. 59-1 at 111 of 263 (comment of AMA).

Ignoring these concerns, HHS again doubles-down on its position that there is no conflict. Indeed, it goes so far as to state that "[p]laintiff may continue to follow EMTALA's requirements without any reasonable fear it will violate the Statutes as implemented by the Rule." ECF No. 64 at 15. But this statement of counsel is without the force of law and the Rule, itself, gives health care providers no such assurance. Instead, the Rule simply states that "where EMTALA might apply in a particular case, the [HHS] would apply both EMTALA and the relevant law under this rule harmoniously *to the extent possible*." 84 Fed. Reg. at 23188 (emphasis added).[7]

As Washington previously established, however, the Rule's provisions

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[7] HHS's attempt to rely on *California v. United States*, No. C 05-00328 JSW, 2008 WL 744840 (N.D. Cal. Mar. 18, 2008) is misplaced. That case involved a constitutional challenge directly to the Weldon Amendment. There, the court indicated there was no conflict between Weldon and EMTALA because the statutes could be harmonized to allow abortion-related services in an emergency. *Id.* at *4. Here, by contrast, Washington is challenging the Rule—not the Weldon Amendment. And the Rule has no exceptions for emergency situations.

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1 simply cannot be reconciled with the fundamental nature of emergency medical
2 care, which may result in a patient dying if, for instance, an ambulance driver
3 refuses to transport a woman with a life-threatening ectopic pregnancy to the
4 hospital because the potential treatment might include abortion, *see id.* at 23188,
5 or if a nurse refuses to treat a patient with such a condition and a replacement
6 nurse cannot be found in time, *see, e.g.*, *Shelton v. Univ. of Med. & Dentistry of*
7 *N.J.*, 223 F.3d 220, 222–23 (3d Cir. 2000) (discussing the claims of a nurse who
8 refused to treat a patient who was suffering from such a condition thereby
9 delaying the patient's necessary life-saving treatment). In addition, the Rule,
10 itself, greatly increases the likelihood of such conflicts occurring as health care
11 providers (i) are now prohibited from asking before hiring an applicant whether
12 the individual has objections to medical activities, even if those objected-to
13 procedures are core functions of the job, 84 Fed. Reg. at 23263 (§ 88.2(5)), and
14 (ii) are dependent upon the employee being willing to "voluntarily accept" a
15 reasonable accommodation in the event a conflict arises, *id.* (§ 88.2(4)). These
16 provisions are particularly problematic in the emergency context because
17 "emergency departments operate on tight budgets and do not have the staffing
18 capacity to be able to have additional personnel on hand 24 hours a day, 7 days a
19 week to respond to different types of emergency situations." ECF No. 59-1 at
20 135–39 of 263 (comment of American College of Emergency Physicians).
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b. The Rule conflicts with other existing healthcare laws

Section 1554. HHS mischaracterizes Washington's argument. Washington challenged as inconsistent with section 1554 the many provisions in the Rule permitting providers to refuse to supply patients medically required information or emergency care, ECF No. 57 at 25, not its allowance of an objecting provider to abstain from performing an abortion. *See* ECF No. 64 at 16. HHS's portrayal of section 1554 reads out of the statute the many words that require HHS's rulemakings to be reasonable—for example, prohibiting HHS from erecting "unreasonable" barriers, impeding "timely" access, interfering with the "full range" of treatment options, or violating well-established professional health care standards. 42 U.S.C. § 18114(1)–(6). Washington does not contend that section 1554 completely straightjackets HHS, as HHS implies, but instead argues that HHS failed to engage in any analysis or attempt to conform its rulemaking to section 1554.

HHS also incorrectly claims that Washington's position conflicts with section 1303(c)(2) of the ACA. ECF No. 64 at 16. But Section 1303(c)(2) states that the ACA does not preempt or limit federal laws relating to conscience protections and abortion. 42 U.S.C. § 18023(c)(2). HHS's position is dependent on the premise that the Rule is coextensive with, and does not exceed, the refusal statutes, which as shown above is incorrect. *See supra* at 10–18. If the Court determines that the Rule exceeds those statutes, then section 1303(c)(2) is

inapplicable by its own terms.

The ACA contraceptive coverage requirement. In Washington's motion, it showed that the Rule vitiates a requirement in the ACA that an employer-sponsored group health plan and health plan issuer (i.e., insurance carrier) include coverage of contraception in their health plans. 42 U.S.C. § 300gg-13(a)(4); ECF No. 57 at 28–29. It does this by exempting religiously affiliated employers and issuers from the obligation to cover contraception without satisfying the accommodation required by the law. *See Zubik v. Burwell*, 136 S. Ct. 1557, 1559 (2016) (per curiam). HHS's only response is to make the same argument as above—i.e., that the Rule is saved by section 1303(c)(2) of the ACA. ECF No. 64 at 16–17; *see also* ECF No. 44 at 43. But as explained above, this argument is flawed. If the Court finds that the Rule exceeds the scope of the refusal statutes, section 1303(c)(2) would not apply, and HHS must be deemed to have conceded that it violates the ACA's contraceptive coverage requirement.

Title X. HHS's response to Washington's showing that the Rule violates the non-directive mandate in annual appropriations riders to Title X again mischaracterizes the State's argument. Washington does not contend that the appropriations riders require pregnancy counseling, as HHS asserts. ECF No. 64 at 18. Instead, it argues that if a Title X provider offers pregnancy counseling, it must be non-directive. The Rule purports to vitiate this requirement by permitting a religious provider to offer pregnancy counseling that omits the option of

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termination. ECF No. 57 at 20.

The motions panel's order in *California v. Azar* (which is consolidated with *Washington v. Azar*) supports this argument. *See California v. Azar*, 927 F.3d 1068, 1077, *reh'g en banc granted*, 927 F.3d 1045 (9th Cir. 2019) (pregnancy counseling, when provided by a Title X provider, must be non-directive). HHS offers no reason that Church, Coats-Snowe, and Weldon, which have existed alongside the annual Title X appropriations rider for many years, somehow superseded the rider's non-directive mandate. HHS's Rule, not the refusal statutes, contradict the non-directive mandate.

4. The Rule is arbitrary and capricious in violation of the APA

a. HHS admits that it misrepresented the central facts supporting the Rule

Remarkably, HHS does not take issue with Washington's showing that the overwhelming majority of the agency complaints it relied on to justify the Rule[8] have nothing at all to do with the purported religious discrimination the Rule addresses. ECF No. 57 at 31–34; *see* ECF No. 64 at 21 ("many of the complaints that OCR received" were "outside the scope of the Federal Conscience Statutes").

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[8] *See* 84 Fed. Reg. at 23175 ("[s]ince November 2016, there has been a significant increase in complaints filed with OCR alleging violations of the laws that were the subject of the 2011 Rule," and this "increase underscores the need for the Department to have the proper enforcement tools" created by the Rule).

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It is important to recognize the sweep of HHS's concession. It does not dispute that 94% of the complaints HHS cited to support the Rule do not relate to the issues addressed by the Rule. While it cites in a footnote nine allegedly relevant complaints, ECF No. 64 at 21 n.4, all but one are included in the 6% of agency complaints that are arguably covered by the Rule's new protections.[9] HHS also does not dispute the many cases holding that rulemaking based on a fabricated record cannot survive review. ECF No. 57 at 31–32, 34. Those cases are dispositive here.

This is not a case presenting a smattering of factual errors. This is a case where an agency either deliberately falsified the factual basis for rulemaking or was so sloppy that it overlooked that 94% of its key evidence did not support the purported harm it was remedying. Such rulemaking does not satisfy the APA. *See id.*; *see also, e.g.*, *Dioxin/Organochlorine Ctr. v. Clarke*, 57 F.3d 1517, 1521 (9th Cir. 1995) (reversal under APA required where agency "offered an explanation for its decision that runs counter to the evidence before the agency"); *Choice Care Health Plan, Inc. v. Azar*, 315 F. Supp. 3d 440, 443 (D.D.C. 2018); *Batalla Vidal v. Nielsen*, 279 F. Supp. 3d 401, 427 (E.D.N.Y. 2018); *City of Philadelphia v. Sessions*, 280 F. Supp. 3d 579, 624 (E.D. Pa. 2017).

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[9] With respect to the one complaint not included in that 6% (HHS Ex. 9, ECF No. 64-9), the underlying conduct in that complaint does not relate to the refusal statutes at issue here.

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1 The 94% of irrelevant agency complaints is not the only damning fact HHS
2 dodges in its opposition brief. HHS also fails to defend the Kellyanne Conway
3 surveys that played a prominent role in HHS's factual justification for the Rule.
4 *See* ECF No. 57 at 36–37. While the preamble to the Rule claims repeatedly that
5 the Conway survey demonstrates that "the failure to protect conscience is a
6 barrier to careers in the health care field," 84 Fed. Reg. at 23246, 23181, 23228,
7 23247, HHS's defense of the Rule in its opposition ignores the survey. *See* ECF
8 No. 59-1 at 11 of 263 (survey narrative stating that it could not be extrapolated
9 outside of the views of the "self-selecting" category of respondents).
10 The limited defense that HHS *does* attempt to shore up the factual basis
11 for the Rule falls remarkably short.
12 First, HHS gamely asserts that the agency complaints cited in the preamble
13 still "underscore the need" to clarify and "more robustly safeguard" the refusal
14 rights protected by the statutes. ECF No. 64 at 21. But the fact that 94% of the
15 complaints have nothing to do with the statutes easily refutes this claim.
16 HHS then contends that the complaints actually now are *not* important,
17 because the *absence* of complaints also demonstrates the public's confusion. *Id.*
18 But the more likely explanation for the absence of relevant complaints is that the
19 purported religious discrimination in health care the Rule purports to address is
20 not prevalent—an explanation buttressed by the vast number of complaints OCR
21 received alleging *other* types of discrimination. *See, e.g.*, Department of Health
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1 and Human Services Office of Civil Rights, *Fiscal Year 2019 Justification of*
2 *Estimates for Appropriations Committee* at 30, https://www.hhs.gov/sites/default
3 /files/fy2019-ocr-congressional-justification-accessible.pdf (last visited Oct. 17,
4 2019) (OCR received 24,523 complaints in FY 2016).

5 Ultimately, however, HHS fails to grapple with the deeply flawed nature
6 of the evidence it marshalled to justify the Rule. It formulaically explains the
7 rationales for the Rule: to dispel confusion and bolster enforcement powers. ECF
8 No. 57 at 19. It then ticks off six categories of purported evidence it considered
9 that supported the rationales, and it contends that merely *considering* this
10 evidence constitutes a reasoned explanation for changing course. *Id.* at 19–20.
11 But Washington is not arguing that the agency did not consider this evidence; it
12 is arguing that the evidence itself was of little value because it was fabricated,
13 misrepresented, and otherwise baseless. A reasoned analysis requires ensuring
14 that the evidence meets a baseline for accuracy and honesty, which HHS failed
15 to do. *See Defs. of Wildlife v. Babbitt*, 958 F. Supp. 670, 682 (D.D.C. 1997).

16 What is transparent here is that HHS's rulemaking reflects a policy choice
17 in search of supportive facts. Washington is not simply litigating a policy
18 disagreement. *See* ECF No. 64 at 19. Elections have policy consequences, but an
19 agency still cannot fabricate the administrative record to support its preferred
20 policy position. Instead, it must identify accurate, honestly presented facts to
21 support the "detailed justification" necessary to support the reversal of its prior
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policy. *FCC*, 556 U.S. at 515. HHS failed to do that here.[10]

b. HHS failed to consider or meaningfully address evidence of the severe harms the Rule will inflict

In its opposition, HHS steadfastly contends that it "considered all important aspects of the problem." ECF No. 64 at 24. But a review of the administrative record belies this contention. As Washington previously established, HHS "brushed aside critical facts," *Am. Wild Horse Pres. Campaign v. Perdue*, 873 F.3d 914, 932 (D.C. Cir. 2017), and failed to "pay[] attention to the advantages *and* the disadvantages" of its decision, *Michigan v. EPA*, 135 S. Ct. 2699 (2015) (emphasis in original). *See* ECF No. 57 at 40–53. Because HHS has no meaningful response to these fatal deficiencies, the Rule is arbitrary and capricious for this reason as well.

Harm to Patients. In its opening brief, Washington explained how the

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[10] HHS's attack of the Molinas declaration is baseless. The Molinas Declaration bears on whether the agency has considered all relevant factors and explained its decision. *See, e.g.*, *San Luis & Delta-Mendota Water Auth. v. Locke*, 776 F.3d 971, 992 (9th Cir. 2014). It does not proffer extra-record evidence. Instead, it describes the disorganized manner in which HHS had compiled the record of agency complaints, and it indexes and describes for the Court the 367 administrative complaints and hundreds of pages of related, often duplicative documents the agency itself inserted into the record. ECF No. 58 ¶¶ 4–9, 10–18.

Rule was promulgated without sufficiently addressing the comments of many national healthcare organizations, healthcare providers, and other national organizations, which warned that the Rule's expansion and prioritization of refusal rights will harm patients and the delivery of health care services. *Id.* at 41–43. In its opposition, HHS continues to dodge these concerns.

HHS's principal response is to tout its ill-founded conclusion that the Rule will "help alleviate the country's shortage of health care providers" by "mak[ing] it easier for health care professionals to perform their jobs while staying true to their religious beliefs or moral convictions." ECF No. 64 at 24. Setting aside the specious nature of this claim (which was based largely upon the unreliable Kellyanne Conway surveys), *see* ECF No. 57 at 55–57 (explaining how the Rule's purported benefits are not supported by competent evidence), this response misses the mark.

As the comments highlighted by Washington make clear, these comments are not alleging harm due to the number of health care providers in the medical industry. Instead, the concern is that the Rule's new provisions—which dramatically expand the number of objectors, while at the same time curtailing employers' ability to learn about and accommodate objections, *see* 84 Fed. Reg. at 23263 (§ 88.2)—will impede health care providers' ability to ensure undisrupted and comprehensive medical services to patients.

While HHS attempts to bat away these comments by labelling them "far-

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fetched harms," ECF No. 64 at 25, HHS offers no reasoned response to them. Nor does HHS dispute that under the Rule:

- A commercial health insurer's employees may refuse to give information on a patient's insurance benefits or coverage if they relate to objected-to services;
- A receptionist may refuse to schedule a patient's pregnancy termination or contraception consultation; and
- An ambulance driver may refuse to transport a woman experiencing significant pregnancy-related complications.

While HHS attempts to minimize these problems by arguing that "Plaintiff's objections boil down to a policy disagreement with Congress over its decision to protect health care entities that have conscience objections to performing certain services," ECF No. 64 at 25–26, HHS is wrong. The above examples reflect scenarios in which a patient could be denied care based solely on the Rule's expansive new definitions. *See* 84 Fed. Reg. at 23263 (§ 88.2); *see also id.* at 23188. Other examples abound. By failing to meaningfully consider and address how the Rule's expansive new definitions would impact patients and the delivery of health care services, HHS failed to conduct the "reasoned analysis" necessary to support agency rulemaking. *Motor Vehicle Mfrs. Ass'n of U.S. v. State Farm Mut. Ins. Co.*, 463 U.S. 29, 42–43 (1983).

Emergencies. As discussed above (*supra* at 18–20) and in Washington's opening brief, ECF No. 57 at 43–46, numerous commenters warned about the Rule's failure to adequately address the rights and needs of a patient undergoing

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an emergency—particularly in situations involving ectopic pregnancy, abortion management, and complications for transgender patients resulting from transition surgery. ECF No. 57 at 44 (citing ECF No. 59-1 at 111 and 136 of 263). Commenters also warned that the Rule fails to address how employers are supposed to respond to an employee who raises an objection in an emergency medical situation—particularly when no other staff is available to treat the patient.[11]

HHS largely attempts to deflect these concerns, pointing to the Rule's statement that "the requirement under EMTALA that certain hospitals treat and stabilize patients who present in an emergency does not conflict with Federal conscience and antidiscrimination laws." 84 Fed. Reg. at 23183; *see* ECF No. 64 at 30. But its reliance on this statement is misplaced. Washington is not alleging a conflict between EMTALA and the underlying statutes. And as noted above,

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[11] HHS contends elsewhere in its brief that it addressed concerns that the Rule could make it impossible for service providers to anticipate objections by modifying its definition of discrimination "to clarify that 'employers may require a protected employee to inform them' of protected conscience objections 'to the extent there is a reasonable likelihood that the protected entity or individual may be asked in good faith' to undertake an objected-to activity." ECF No. 64 at 26. But this clarification does not address emergency situations, in which an employee may voice an objection for the first time.

1 these statutes have been interpreted to allow for emergency abortions. *See supra*
2 at 19 n.7. Instead, Washington is challenging the new conscience rights
3 established by the Rule, which do not provide an emergency exception.
4 HHS's contention that Washington is simply bandying about "hypothetical
5 scenarios" is similarly misplaced. ECF No. 64 at 31. HHS cannot dispute that the
6 Rule itself acknowledges situations in which an ambulance driver might refuse
7 to transport a patient suffering from a life-threatening ectopic pregnancy, 84 Fed.
8 Reg. at 23188, and Washington has already provided the example of a nurse who
9 refused to provide services to a patient requiring emergency interventions for
10 such a condition thereby delaying the patient's life-saving treatment. *Shelton*, 223
11 F.3d 220. *See also* ECF No. 63-1 at 12–13 (Amicus Br. of Leading Medical
12 Orgs.). These concerns are compounded by the comment of the American
13 College of Emergency Physicians, which warned HHS that "[p]atients with life-
14 threatening injuries or illnesses may not have time to wait to be referred to
15 another physician or other healthcare professional to treat them if the present
16 provider has a moral or religious objection." ECF No. 59-1 at 136 of 263.
17 Notwithstanding the life-or-death nature of these concerns, the Rule does
18 nothing more than pay lip service to EMTALA. By failing to meaningfully
19 discuss and consider how the Rule's new terms will impact the provision of
20 emergency medical services, HHS "entirely failed to consider an important
21 aspect of the problem." *AEP Tex. N. Co. v. Surface Transp. Bd.*, 609 F.3d 432,
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441 (D.C. Cir. 2010). For this reason too, the Rule is arbitrary and capricious.

Vulnerable Populations. HHS largely ignores Washington's arguments on the Rule's impact on vulnerable populations. Instead, it generally states that "'[a]ccess to care is a critical concern' of HHS," and that the agency "examined commenters' concerns closely" but found no "data or persuasive reasoning, presented by commenters or otherwise, demonstrating that the Rule would negatively impact access to care." ECF No. 64 at 24 (citing 84 Fed. Reg. 23180–82, 23253–55). But a review of the Rule's discussion of this issue and the related comments submitted to HHS undermines this assertion.

First, HHS's determination that the Rule will not harm access to care was largely based on the prior 2008 Rule. *See* 84 Fed. Reg. at 23180 (discussing the prior 2008 Rule and stating that "[t]he Department agrees with its previous response"). The Rule's discussion of this issue, however, does not acknowledge or discuss the agency's 2011 Rule, which found that the 2008 Rule would "negatively affect the ability of patients to access care if interpreted broadly." *See* 76 Fed. Reg. 9968, 9974 (Feb. 23, 2011) (partially rescinding the 2008 Rule based on these concerns). Moreover, the Rule's discussion on this issue also neglects to consider that the new Rule goes beyond the 2008 Rule, by, among other things, adopting an overbroad definition of "discrimination." *See supra* at 18 n.6.

Second, while HHS states that it was given no "data or persuasive

1 reasoning, presented by commenters or otherwise, demonstrating that the Rule
2 would negatively impact access to care," ECF No. 64 at 24, this is only because
3 the agency chose to disregard the "anecdotal accounts of discrimination from
4 LGBT" people based on its determination that such accounts "offer no suitable
5 data for estimating the impact of this rule" *See* 84 Fed. Reg. at 23252. But as
6 Washington previously explained, HHS's decision to discount anecdotal
7 evidence from the LGBT community cannot be reconciled with its extensive
8 reliance on anecdotal evidence elsewhere to support the Rule. *See* ECF No. 57 at
9 48–49 (cataloguing HHS's reliance on anecdotal evidence to support the Rule).
10 In its opposition, HHS offers no response to Washington's argument that the
11 agency's internally inconsistent treatment of anecdotal evidence renders the
12 rulemaking process arbitrary and capricious. HHS's failure to respond on this
13 issue is fatal to its claim of neutral rulemaking. *Water Quality Ins. Syndicate v.*
14 *United States*, 225 F. Supp. 3d 41, 69 (D.D.C. 2016) (reversing agency decision
15 that "cherry-pick[ed] evidence"); *see also, e.g.*, Amicus Br. of Scholars of the
16 LBGT Population, ECF No. 53-1 (focusing on the harms the Rule will impose on
17 LGBT people and providing AR cites for these objections); Amicus Br. of Nat'l
18 Ctr. for Lesbian Rights, ECF No. 55-1 (similar).
19 **Medical Ethics**. HHS also gives short shrift to Washington's argument
20 that the Rule failed to meaningfully consider the serious impacts it would have
21 on medical ethics. ECF No. 64 at 29. While HHS argues that its treatment of
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1 medical ethics issues in the Rule "was not 'conclusory,' " a review of the Rule's
2 few boilerplate sentences on the issue belies this contention. *See* 84 Fed. Reg. at
3 23189, 23200. Moreover, as the Amicus Brief of Leading Medical Organizations
4 submitted in this case makes clear, "[t]he Rule is fundamentally irreconcilable
5 with medical ethics because the Rule: (1) permits refusal to provide necessary
6 services, even in cases of emergency; (2) fails to protect continuity of care for all
7 patients; and (3) permits individuals without medical training to impede patient
8 treatment." ECF No. 63-1 at 10–17; *see also* ECF No. 59-1 at 106–112 (comment
9 of American Medical Association). Thus, HHS's failure to conduct a reasoned
10 analysis of the Rule's contravention of medical ethics is arbitrary and capricious.
11 **Title VII**. In a bold and weakly supported repudiation of Title VII's
12 regulatory framework for handling religious objections in the workplace, the
13 Rule greatly expands an employee's ability to refuse to provide healthcare
14 services by requiring that any accommodation be "voluntarily accepted" and
15 restricting inquiry into whether employees have religious objections to their
16 duties. 84 Fed. Reg. at 23263 (§ 88.2). HHS does nothing to bolster the superficial
17 explanation in the Rule's preamble for a complete overhaul of the Title VII
18 standard that has effectively governed workplaces for decades. *See id.* at 23190–
19 91. But this explanation fails to acknowledge the healthcare context in which the
20 Rule will be operating, whereby employers are dependent upon their staff being
21 able to provide medical attention in time-sensitive and potentially life-threatening
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situations. Nor does this explanation provide any analysis of how the Rule's new accommodation process will work or respond to employers concerns regarding the "operational challenges" created by the Rule's definition of discrimination. *See, e.g.*, ECF No. 59-1 at 30 of 263 (comment of Kaiser Permanente). Simply put, HHS's cursory discussion in the Rule's preamble fails to provide the "reasonable explanation" necessary to justify a departure from decades of settled law. *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126 (2016).

B. The Rule Is Unconstitutional

1. The Spending and Establishment Clause Claims Are Ripe

Washington's Spending and Establishment Clause claims are ripe for review. ECF No. 57 at 3–5. While the ripeness doctrine evaluates the "fitness of the issues for judicial decision and the hardship to parties of withholding court consideration," *Abbott Labs. v. Gardner*, 387 U.S. 136, 149 (1967), HHS erroneously oversimplifies this analysis in its response, mischaracterizing it as "whether the Court would benefit" by waiting and whether there would be harm in the interim. ECF No. 64 at 31. But in *Abbott*, the Court held that issues are appropriate for judicial resolution prior to an enforcement action if the issues are purely legal and both parties moved for summary judgment. 387 U.S. at 149. Those conditions are readily satisfied here.

Abbott also instructs that judicial review is appropriate *prior* to an enforcement action where, as here, regulations "purport to give an authoritative

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interpretation of a statutory provision that has a direct effect on the day-to-day business" and places the regulated entities in the "dilemma" of either incurring the cost of compliance or risking an enforcement action. 387 U.S. at 152. While HHS contends that Washington has provided "no reason" it could not seek judicial relief *after* facing an enforcement action, ECF No. 64 at 31), this argument ignores Washington's evidence that it will have to spend millions of dollars in compliance efforts or risk losing billions of dollars in an enforcement action. *See* ECF No. 57 at 3–4; ECF No. 8 at 13–14, 40–42, 44-45, 52. Here, Abbott controls and Washington's constitutional claims are ripe for review.[12]

2. The Rule violates the constitutional separation of powers

As Washington established in its opening brief, the Rule violates the constitutional separation of powers doctrine because it purports to give an Executive Branch agency the unilateral authority to refuse to spend funds appropriated by Congress. ECF No. 57 at 57–58. Here, HHS gives itself the unilateral authority to terminate billions of dollars in congressionally appropriated federal funds under the Rule's new enforcement framework. ECF No. 57 at 11–24. HHS fails to address this argument.

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[12] The case HHS principally relies upon actually supports justiciability. *See* *NFPRHA*, 468 F.3d at 829 (although plaintiffs lacked standing, outcome would be different if the plaintiffs had to choose between the considerable expense of compliance or risk after-the-fact fines and reputational losses).

Instead, HHS mischaracterizes Washington's argument as a "suggest[ion] that the Rule changes the amount of money or funding sources affected by the Federal Conscience Statutes." ECF No. 57 at 37. It then responds to this mischaracterized argument, by stating that the Rule does not change any substantive requirements. *Id*. But, as Washington has explained, the Rule *does* change the substantive requirements of the statutes. *Supra* at 10–18. Therefore, HHS's response is unavailing.

3. The Rule violates the Spending Clause

HHS also fails to provide any meaningful response to Washington's argument that the Rule violates the Spending Clause because it imposes conditions that are so coercive that they compel (rather than encourage) compliance, *see Nat'l Fed'n of Indep. Bus. v. Sebelius* (*NFIB*), 567 U.S. 519, 575–78 (2012), and permits the termination of the State's funding based on the conduct of sub-recipients, *see Gebser v. Lago Vista Indep. Sch. Dist.*, 524 U.S. 274, 287–88 (1998) (notice required).

Instead, HHS dodges these arguments, arguing instead that the Rule "merely implements the Statutes." ECF No. 64 at 33. But this dismissive response completely ignores the many substantive changes the Rule imposes. *See* ECF No. 57 at 11–24 (detailing new conditions); *supra* at 10–18. It also fails to account for the significant expenditures Washington must undertake in order to ensure compliance with the Rule's new provisions, *see* ECF No. 8 at 13–14, 40–42, 44–

1 45, 52)—efforts that are required by the Rule's compliance, assurance, and
2 certification requirements, *see* 84 Fed. Reg. at 23269 (§ 88.4(a)(1), (2))
3 (compliance for continued funding). HHS also fails to acknowledge that the Rule
4 now allows HHS to terminate State funding based on the conduct of
5 subrecipients. *See id.* at 23270–71 (§§ 88.6, 88.7(i)(3)(iv)–(v)), 23180.

6 While HHS attempts to distinguish *NFIB* by arguing the "Rule's
7 enforcement will remain individualized and will begin with informal means,"
8 ECF No. 64 at 32–33, this statement rings hollow when the Rule specifically
9 authorizes HHS to terminate federal funding during the pendency of good faith
10 compliance efforts and before a finding of noncompliance. 45 C.F.R. §§
11 88.7(i)(2), 88.7(j). Therefore, because HHS's draconian enforcement scheme
12 leaves Washington with "with no real option but to acquiesce" to the Rule's new
13 conscience rights, this constitutes "economic dragooning" and violates the
14 Spending Clause. *NFIB*, 567 U.S. at 581.

15 **4. The Rule violates the Establishment Clause**

16 HHS contends that the Rule cannot violate the Establishment Clause
17 because the underlying federal statutes do not. ECF No. 64 at 33–34. This is a
18 non sequitur. As Washington has explained, this action challenges the *new*
19 conscience rights created by the Rule, which, among other things, imposes an
20 absolute obligation on employers to accommodate employees' religious beliefs
21 irrespective of burden and abandons the long-standing framework applied to
22

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religious accommodations in health care under Title VII. *See supra* at 16–18, 34.

HHS argues that the Rule is "generally neutral between religion and nonreligion" and that this is "strong evidence" that it does not violate the Establishment Clause. *See* ECF No. 64 at 33–37. But the fact that the Rule protects "moral" objections as well as religious ones does not make it neutral towards religion and nonreligion. *See Larkin v. Grendel's Den, Inc.*, 459 U.S. 116, 120 (1982) (law that allowed churches *and schools* the ability to veto liquor licenses violated the Establishment Clause). Nor does the fact that the underlying statutes protect entities from choosing not to perform abortions make the Rule neutral toward religion given the historical political tie between religion and abortion. *See Walz v. Tax Comm'n of City of NY*, 397 U.S. 664, 695 (1970) (Harlan, J., concurring) ("religious groups inevitably represent certain points of view and not infrequently assert them in the political arena, as evidenced by the continuing debate respecting birth control and abortion laws"). Instead, as Washington has shown throughout its briefing, the Rule's text and record demonstrate that it was primarily intended to advance and privilege specific religious beliefs in violation of the Establishment Clause.

HHS attempts to distinguish *Thornton*, arguing that the issue there was "not the provision of an 'absolute and unqualified' right, but rather that the statute benefited only the religious." ECF No. 64 at 35. This reading is not credible. The essential holding of *Thornton* is that a law that requires some accommodation of

an employee's religious observance would not necessarily violate the Establishment Clause; but a law imposing "an absolutely duty to conform [] business practices to the particular religious practices of the employee" does. *Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 709 (1985). That is precisely what the Rule does here through its new provisions. *See* 84 Fed. Reg. at 23263 (§ 88.2), 23191.

Lastly, HHS argues that "the Establishment Clause does not flatly prohibit accommodations that may burden third parties." ECF No. 64 at 36. But, as the Supreme Court made clear in *Thornton*, it does flatly prohibit imposing an "absolute duty" to conform business practices to the religious beliefs of an employee. *Thornton*, 472 U.S. at 709. Thus, this argument fails as well.

C. The Court Should Vacate the Rule

HHS's attempt to rely on *Gill v. Whitford*, 138 S. Ct. 1916, 1934 (2018)—a voting rights case dealing with political gerrymandering in Wisconsin—to argue that relief should be limited to Washington is nonsensical. Accordingly, for the reasons previously set forth, ECF No. 57 at 67–70, the Rule should be vacated in its entirety pursuant to 5 U.S.C. § 706(2).

III. CONCLUSION

For the reasons set forth above, and in its prior briefing, the State of Washington respectfully requests that the Court grants its motion for summary judgment and vacate and set aside the Rule in its entirety.

RESPECTFULLY SUBMITTED this 18th day of October, 2019.

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DECLARATION OF SERVICE

I hereby declare that on this day I caused the foregoing document to be electronically filed with the Clerk of the Court using the Court's CM/ECF System which will serve a copy of this document upon all counsel of record.

DATED this 18th day of October, 2019, at Seattle, Washington.

/s/ Jeffrey T. Sprung
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