20-15398(L)

20-15399(CON), 20-16045(CON), 20-35044(CON)

United States Court of Appeals for the Ninth Circuit

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff-Appellee,

v.

ALEX M. AZAR II et al.,
Defendants-Appellants.

COUNTY OF SANTA CLARA et al.
Plaintiffs-Appellees,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES et al.,
Defendants-Appellants.

(*caption continues inside front cover*)

On Appeal from the United States District Courts for the
Northern District of California and the Eastern District of Washington

BRIEF FOR STATES OF NEW YORK, COLORADO, CONNECTICUT, DELAWARE, HAWAI'I, ILLINOIS, MAINE, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, NEVADA, NEW JERSEY, NEW MEXICO, NORTH CAROLINA, OREGON, PENNSYLVANIA, RHODE ISLAND, VERMONT, VIRGINIA, AND WISCONSIN, AND THE DISTRICT OF COLUMBIA, AS *AMICI CURIAE* IN SUPPORT OF STATES OF CALIFORNIA AND WASHINGTON

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STATE OF CALIFORNIA,
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Defendants-Appellants.

STATE OF WASHINGTON,
Plaintiff-Appellee,
v.
ALEX M. AZAR II et al.,
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INTRODUCTION AND INTERESTS OF AMICI

Amici States of New York, Colorado, Connecticut, Delaware, Hawaiʻi, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, North Carolina, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, and Wisconsin, and the District of Columbia, submit this brief in support of the challenges brought by California and Washington to a May 2019 federal rule that vastly and unreasonably expands the ability of health care providers to deny patients access to certain lawful and medically needed procedures, services, and information, including that related to abortion, sterilization, and aid-in-dying. The rule, promulgated by the U.S. Department of Health and Human Services (HHS), purports to implement various federal conscience statutes. Protecting Statutory Conscience Rights in Health Care: Delegations of Authority, 84 Fed. Reg. 23,170 (May 21, 2019) (codified at 45 C.F.R. pt. 88) (the "Rule").

In reality, however, the Rule violates the careful balance Congress has struck in the underlying statutes by simultaneously expanding the job functions that objectors may refuse to perform based on their personal views, and severely restricting the actions that employers may take to

plan for and accommodate such objections while ensuring that patients receive uninterrupted care. All of the federal courts to consider the Rule have agreed that it is not authorized by law, and have accordingly vacated the Rule in full. This Court should affirm.

Amici States are both providers and regulators of health care: we own and operate public hospital systems, employ individual health care personnel, and license and regulate the many other health care providers that operate within our jurisdictions. Like Congress, many of Amici States' legislatures have enacted laws recognizing the right of health care providers to object to participating in certain medical procedures on religious or conscience grounds. But such laws must still ensure that patients can continue to receive the care that they need, including in emergencies, and that providers adhere to their professional obligations. For decades, Amici States have developed and enforced policies consistent with both federal and state laws that carefully balance these important interests.

Like California and Washington, Amici States are harmed by the Rule's abrupt upending of this decades-long status quo, and by the accompanying threat of the loss of many billions of dollars of critical federal health care funds. Amici States therefore have a significant interest

in the outcome of this appeal. Indeed, many Amici States have filed our own lawsuits challenging the Rule.[1]

As demonstrated in the well-reasoned opinions of the district courts under review here, the Rule is infirm on several independent grounds. Among them are the Rule's several definitional provisions, which in conjunction expand the reach of the federal conscience statutes beyond the carefully tailored protections—including those against "discrimination"—that Congress sought to confer on providers who object to participating in certain procedures.

Amici States write here to separately emphasize the particularly harmful impacts arising from the Rule's expansive redefinition of the "discrimination" that is prohibited by the Rule, and to highlight some of the fundamental procedural defects that infected HHS's rulemaking. The Rule radically departs from longstanding understandings of "discrimination," as the term has been used by Congress in other federal statutes

[1] *See New York v. United States Dep't of Health & Human Servs.*, No. 19-4254(L) (2d Cir.) (suit brought by New York, Colorado, Connecticut, Delaware, District of Columbia, Hawai'i, Illinois, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, Wisconsin, the cities of New York and Chicago, and Cook County, Illinois).

(and by HHS in prior guidance), and prohibits Amici States and health care employers in our jurisdictions from inquiring in advance about whether providers are able to perform essential job functions. In doing so, the Rule has placed Amici States in the untenable position of having to choose between ensuring the health and safety of our residents or potentially losing billions of dollars of much-needed federal health care funds.

HHS also failed to undertake the reasoned decisionmaking required by the Administrative Procedure Act (APA). In promulgating the Rule, HHS gave no consideration to stakeholders' decades-long reliance on HHS's prior guidance—and indeed did not even acknowledge that the new "discrimination" definition represents a change in policy in the first place. Instead, HHS proffered an empirical justification for the Rule's sweeping scope that is contradicted by the record. HHS's deeply flawed reasoning provides an independent basis for vacatur of the Rule.

FACTUAL BACKGROUND

A. Federal Laws Balancing Patients' Right to Access Health Care and Providers' Objections to Particular Procedures

Over the span of nearly four decades, Congress has legislated to protect patients' access to care, while recognizing that some health care providers may have objections to participating in certain procedures on religious or moral grounds. Five federal statutes concerning conscience objections to certain medical procedures and services—including abortion, sterilization, and aid-in-dying—are at issue in this case. Among other things, the Rule purports to interpret several statutory terms contained in these statutes, including "discriminate" or "discrimination" as used in the Church, Coats-Snowe, and Weldon Amendments, and in provisions of the Patient Protection and Affordable Care Act of 2010 (ACA).[2] *See* 45 C.F.R. § 88.2.

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[2] Although this brief focuses on the Rule's redefinition of "discrimination," Amici States agree with California and Washington that the Rule's other definitional provisions—including those for "assist in the performance," "health care entity," and "referral and refer for"—are also contrary to law, for the reasons set forth in California's and Washington's briefs, and in the California district court's written decision. *See* Br. of Pl.-Appellee State of California at 16-22; Br. of Pl.-Appellee State of Washington at 33-43. (*See also* Excerpts of Record 45-54, 57-59.)

As relevant here, the Church Amendment, enacted in 1973, prohibits, among other things, "discrimination" by entities receiving federal funds under the Public Health Service Act[3] in the employment context, on the basis of a provider's "religious beliefs or moral convictions respecting sterilization procedures or abortions." *See* 42 U.S.C. § 300a-7(c)(1). As explained by the sponsor of the Church Amendment, a provider's religious or moral objections would not be a basis for "deny[ing] . . . services" in "emergency situation[s]." 119 Cong. Rec. 9601 (Mar. 27, 1973).

More than two decades later, in 1996, Congress passed the Coats-Snowe Amendment, which prohibits government entities receiving federal funds from subjecting physicians and physician trainees, among others, to "discrimination" based on the individual's refusal to undergo training for the performance of abortions, or refusal to participate in the performance of abortions. 42 U.S.C. § 238n(a).

In 2004, Congress enacted the Weldon Amendment as a rider to an appropriations act for the Departments of Labor, Education, and HHS.

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[3] The Church Amendment references two other funding statutes, both of which have been subsequently repealed by Congress. *See* 84 Fed. Reg. at 23,171 n.3.

The Weldon Amendment prohibits federal funds "made available in this Act" from being provided to "a State or local government" if the government "subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions." *See* Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, § 507(d)(1), 133 Stat. 2534, 2607 (2019). Statements of the statute's sponsor confirm that the law does not interfere with "access to life-saving care" in "emergency situations," and does not override potential patient needs for urgent care. *See* 151 Cong. Rec. H177 (Jan 25, 2005).

Finally, in the ACA, Congress prohibited government agencies receiving ACA funds from "subject[ing] an individual or institutional health care entity to discrimination on the basis that the entity does not provide any health care item or service" for the purpose of causing or assisting in causing "the death of any individual, such as by assisted suicide, euthanasia, or mercy killing." 42 U.S.C. § 18113(a). The ACA also prohibits health care insurance plans offered through the ACA exchange from "discriminat[ing] against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide

coverage of, or refer for abortions." *Id.* § 18023(b)(4). In the same Act, Congress also prohibited HHS from promulgating any regulation that, among other things, "impedes [a patient's] timely access to health care services," or "violates the principles of informed consent and the ethical standards of health care professionals." *See id.* § 18114(2), (5).

Over the same period, Congress also acted to ensure patient access to care in emergency situations, and to protect patient rights to be fully informed about their conditions and treatment options. In 1986, Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA), which mandates that hospitals that participate in Medicare provide "necessary stabilizing treatment for emergency medical conditions" for all patients. *Id.* § 1395dd(b). EMTALA's requirements contain no exceptions based on an individual provider or hospital's conscience-related objections to providing treatment in emergency situations. *See Matter of Baby K.*, 16 F.3d 590, 596 (4th Cir. 1994).

Similarly, in 1996, in amending certain statutes concerning Medicaid and Medicare managed-care plans, Congress exempted such plans from being required to provide or cover "a counseling or referral service" if the organization "objects to the provision of the service on moral or religious

grounds," but nonetheless made clear that these exemptions "shall not be construed to affect" relevant state laws governing informed consent and patient disclosure. *See* 42 U.S.C. §§ 1395w-22(j)(3)(B), (C), 1396u-2(b)(3)(B). At the same time, Congress provided that organizations offering Medicaid and Medicare managed-care plans "shall not prohibit or otherwise restrict" individual providers from advising a patient about the treatment options for the patient's health condition, regardless of whether the medically indicated treatment was offered or covered by the organization's plan. *See id.* §§ 1395w-22(j)(3)(A), 1396u-2(b)(3)(A).

B. State Laws and Institutional Policies Respecting Conscience Objections in Health Care

Many Amici States have longstanding laws recognizing that health care providers may have objections to participating in specific medical procedures based on religious and conscience grounds,[4] and protecting

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[4] *See, e.g.*, N.Y. Civil Rights Law § 79-i(1) (1971); Colo. Rev. Stat. § 15-18.7-105 (2010); Conn. Agencies Regs. § 19-13-D54(f) (1974); Del. Code Ann. tit. 16, § 2508(e)-(g) (1996); *id.* tit. 24, § 1791 (1969); 745 Ill. Comp. Stat. §§ 70/4, 70/5 (1998); Md. Code Ann., Health–Gen. § 20-214 (1982); Me. Rev. Stat. Ann. tit. 22, § 1592 (1977); Mich. Comp. Laws § 333.20182 (1978); N.C. Gen. Stat. § 14-45.1(e)-(f) (1967); N.J. Stat. Ann. §§ 2A:65A-1, 2A:65A-2 (1974); Or. Rev. Stat. § 435.485 (1969); 43 Pa. Cons. Stat. § 955.2 (1973); 23 R.I. Gen. Laws § 23-17-11 (1956); Va. Code

providers from discrimination on the basis of their beliefs.[5] Indeed, some of Amici States' conscience statutes predated Congress's first enactment of such laws in 1973. *See* N.Y. Civil Rights Law § 79-i(1) (1971); Del. Code Ann. tit. 24, § 1791 (1969); 23 R.I. Gen. Laws § 23-17-11 (1956). And some are broader in scope than their federal counterparts.

For example, in 1971, two years before the Church Amendment, New York enacted its conscience protection statute, which makes it a misdemeanor for any person or hospital to discriminate against an individual for refusing "to perform or assist in [an] abortion" when doing so "is contrary to [his or her] conscience or religious beliefs." N.Y. Civil Rights Law § 79-i(1). Pennsylvania law prohibits as "an unlawful discriminatory practice" the imposition of any disciplinary action or penalties based on refusals by any medical staff "to perform or participate in abortion or sterilization by reason of objection thereto on moral, religious

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Ann. § 18.2-75 (1975); Vt. Stat. Ann. tit. 18, §§ 5285, 5286 (2013); Wis. Stat. § 253.09(3) (1973).

[5] *See, e.g.*, N.Y. Exec. Law § 296(10); D.C. Code §§ 2-1402.11, 2-1402.31; Haw. Rev. Stat. § 378-2; Mass. Gen. Laws ch. 151B, § 4(1A); Minn. Stat. § 363A.08, subd. 2; N.M. Stat. Ann. § 28-1-7(A)-(C); Vt. Stat. Ann. tit. 21, § 495(a).

or professional grounds, or because of any statement or other manifestation of attitude" by such staff. *See* 43 Pa. Cons. Stat. § 955.2(b)(2). And Connecticut law provides that "[n]o person shall be required to participate in any phase of an abortion that violates his or her judgment, philosophical, moral or religious beliefs." Conn. Agencies Regs. § 19-13-D54(f).

At the same time, like Congress, Amici States recognize the importance of patients' ability to access health care, and the need to ensure that such access not be disrupted even while accommodating the objections of individual providers to specific medical procedures. Accordingly, Amici States' legislatures have also enacted informed consent laws to ensure that patients are able to meaningfully participate in decisions about their care and treatment;[6] laws mandating that patients receive continuous and

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[6] *See, e.g.*, N.Y. Pub. Health Law § 2805-d; Del. Code Ann. tit. 18, § 6852; D.C. Mun. Regs., tit. 22-B, § 2022; Haw. Rev. Stat. § 671-3(b)(4)-(6); 410 Ill. Comp. Stat. § 50/3; Md. Code Ann., Health–Gen. § 19-342; Mass. Gen. Laws ch. 111, § 70E; Minn. Stat. § 144.651, subd. 9; N.J. Stat. Ann. § 26:2H-12.8(d); Or. Rev. Stat. § 677.097; 40 Pa. Cons. Stat. § 1303.504; R.I. Gen. Laws § 23-4.7-2; Vt. Stat. Ann. tit. 12, § 1909; Wis. Stat. § 448.30.

necessary care; and laws prohibiting health care providers from abandoning patients.[7]

For decades, consistent with these longstanding state and federal mandates, health care institutions across the country—including those owned and operated by Amici States—have adopted policies balancing conscience objections to particular procedures with the institutions' obligations to ensure that the provision of medical care is not compromised. (*See, e.g.*, Supplemental Excerpts of Record (S.E.R.) 124-125 (comment letter from the American Hospital Association describing hospitals' "time-tested" framework for accommodating conscience objections while ensuring access to care).) Such policies typically provide that institutions will endeavor to accommodate an individual objector, as long as the institution is given sufficient advance notice of the objection and the accommodation can reasonably be made in light of staffing constraints without compromising patient care or violating legal or ethical standards. (*See, e.g.*, Excerpts of Record (E.R.) 43 (detailing policies of Zuckerberg

[7] *See, e.g.*, N.Y. Educ. Law § 6530(30); 8 N.Y.C.R.R. § 29.2; Conn. Agencies Regs. § 19a-580d-9(a); 225 Ill. Comp. Stat. § 60/22(A)(16); N.M. Stat. Ann. § 61-6-15(D)(24); 49 Pa. Code § 16.61(a)(17); R.I. Gen. Laws § 5-37-5.1; 18 Va. Admin. Code § 85-20-28(B); Wis. Stat. § 448.02(3)(c).

San Francisco General Hospital); S.E.R. 160-161 (describing conscience objection accommodation policies of major Wisconsin health care provider), 320-321 (describing generally prevalent conscience objection policies in New York, New Jersey, Connecticut, and Rhode Island hospitals), 406 (Massachusetts hospital policies).)

ARGUMENT

THE CHALLENGED RULE VIOLATES THE ADMINISTRATIVE PROCEDURE ACT

The APA instructs courts to "hold unlawful and set aside agency action" when the challenged action is "arbitrary" and "capricious," or "not in accordance with law." 5 U.S.C. § 706(2)(A), (C). The district courts below properly concluded that the Rule is unlawful on both of these independent grounds, as well as numerous others. This Court should affirm.

The U.S. District Court for the Northern District of California (Alsup, J.) concluded that the Rule's "persistent and pronounced redefinition of statutory terms . . . significantly expands the scope of the protected conscientious objections . . . in derogation of the actual balance struck by Congress." (E.R. 45.) The U.S. District Court for the Eastern District of Washington (Sebastian, J.) also found the Rule contrary to law

and arbitrary and capricious—adopting the reasoning of the U.S. District Court for the Southern District of New York (Engelmayer, J.), which had also invalidated the Rule. (E.R. 29-30.) *See New York v. United States Dep't of Health & Human Servs.*, 414 F. Supp. 3d 475 (S.D.N.Y. 2019).

Specifically, as the Washington and New York courts properly concluded, HHS acted contrary to law in adopting a new definition of "discrimination" that is inconsistent with the longstanding and commonly understood meaning of the term. *See New York*, 414 F. Supp. 3d at 536-37. That unprecedented redefinition poses severe disruptions to Amici States' health care systems and our ability to deliver seamless patient care while accommodating conscience objections, and is thus particularly harmful to Amici States' interests as health care providers, employers, and regulators. And although not separately discussed here, the Rule's other definitions of statutory terms—which similarly go beyond the statutes themselves—are likewise contrary to law, as all three of the district courts concluded. (E.R. 30, 45-59.) *See New York*, 414 F. Supp. 3d at 523-26.

The Washington and New York courts also correctly found that HHS acted arbitrarily and capriciously in promulgating the Rule. *See New York*, 414 F. Supp. 3d at 540-58. As the administrative record

demonstrated, before the Rule's promulgation, hospitals and other health care institutions had adopted policies, made hiring and staffing decisions, and entered into contracts, all based on a decades-long understanding of their obligations under the federal and state conscience statutes. In dramatically altering this status quo in 2019, HHS utterly failed to acknowledge this legitimate reliance, let alone provide the reasoned explanation for its radical departure from its longstanding past policy that the APA requires. *See Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126 (2016).

Instead, HHS justified the Rule's sweeping provisions on empirical claims of "significant" increases in conscience statute complaints that HHS now does not dispute are unsupported by the record. In relying on such unsupported evidence, and disregarding the serious reliance interests based on the longstanding status quo, HHS failed to discharge its basic obligation under the APA to "engage in reasoned decisionmaking." *See Department of Homeland Sec. v. Regents of Univ. of Cal.*, 140 S. Ct. 1891, 1905 (2020).

A. The Rule Is Contrary to Law

1. The Rule's expansive definition of "discrimination" impermissibly expands the term beyond the meaning intended by Congress.

Four of the five federal conscience statutes underlying the Rule prohibit "discrimination" against certain individuals or health care entities based on conscience objections to participating in certain medical procedures. *See, e.g.*, 42 U.S.C. §§ 238n(a)(1)-(2) (training for abortion procedures), 300a-7(c), (e) (abortion and sterilization), 18113(a) (aid-in-dying), 18023(b)(4) ("refer for" abortions); Pub. L. No. 115-245, § 507(d)(1), 132 Stat. 2981, 3118 (2018) ("provide, pay for, cover, or refer for" abortions). Although the statutes do not define "discrimination," at the time that Congress enacted the first such statute (the Church Amendment), an extensive body of federal law had already developed under Title VII and similar antidiscrimination statutes that gave content to the meaning of the word "discriminate."

It was this body of law that led HHS to conclude in 2008 (during its earlier rulemaking), that there was no need to define "discrimination" under the conscience statutes because the statutory term had a "widely understood" meaning informed by "significant federal case law" under

Title VII and similar statutes. *See* 73 Fed. Reg. 78,702, 78,077, 78,085 (Dec. 19, 2008) (HHS's "enforcement of the provider conscience laws will be informed . . . by comparison to Title VII religious discrimination jurisprudence."). That conclusion properly reflected the well-established presumption that Congress intends statutory terms to have their "ordinarily accepted meaning" unless it defines the terms differently in a particular statute. *See NLRB v. Highland Park Mfg. Co.*, 341 U.S. 322, 325 (1951). The Supreme Court has applied this principle specifically to the meaning of the word "discrimination," holding that Congress's use of that term in Title IX of the Education Amendments Act of 1972 encompassed retaliation—despite the absence of any specific reference in Title IX—when the "general prohibition" on "discrimination" in other federal statutes, including Title VII, had previously been interpreted to cover retaliation. *Jackson v. Birmingham Bd. of Educ.*, 544 U.S. 167, 176 (2005).

Here too, Congress's use of the term "discriminate" (or "discrimination") without further elaboration or definition in the federal conscience statutes evinces its intent to adopt the well-settled understanding of that term under federal antidiscrimination law, including Title VII. And yet the Rule nonetheless consciously breaks from the settled

understanding of "discriminate" in a number of ways, adopting instead a lengthy definition that would label a broad range of conduct impermissible discrimination that could trigger the loss of billions of dollars of federal funding. *See* 84 Fed. Reg. at 23,263. But nothing in the text or the legislative history of the relevant conscience statutes gives any indication that Congress intended to authorize HHS to so thoroughly discard the key features of the well-established antidiscrimination framework from Title VII and other statutes.

First, as HHS acknowledges (Br. for Appellants (Br.) at 42), the Rule's definition of "discriminate" does not incorporate the familiar doctrine that an employer complies with its Title VII obligations so long as it makes "reasonable accommodations" for the employee's religious practices and such accommodations will not impose an "undue hardship" on the employer. *See Trans World Airlines, Inc. v. Hardison*, 432 U.S. 63, 72 (1977); 42 U.S.C. § 2000e(j). Under that doctrine, courts have recognized that employees do not suffer from unlawful discrimination when they are not given the specific accommodation that they request, so long as the employer offers them an accommodation that is reasonable under the

circumstances.[8] Even HHS's (subsequently rescinded) 2008 rule, which suggested that the federal conscience statutes might provide broader protections than Title VII under certain circumstances, concluded that an employer need only provide a reasonable accommodation to satisfy those statutes; thus, "employers have no obligation under the health care conscience protection laws to employ persons who are unqualified to perform the functions required of the jobs that they seek to fill," even if the "unwillingness to perform those functions [is based] on conscience grounds." *See* 73 Fed. Reg. at 78,085. The Rule would abandon these principles and "decline[] to protect an employer who, on account of hardship," cannot grant an accommodation demanded by an objecting employee, no matter how unreasonable that demanded accommodation may be. *See New York*, 414 F. Supp. 3d at 513.

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[8] *See, e.g.*, *Ansonia Bd. of Educ. v. Philbrook*, 479 U.S. 60, 69 (1986); *Rodriguez v. City of Chicago*, 156 F.3d 771, 776-77 (7th Cir. 1998) (employer not required to relieve police officer of duties guarding abortion clinics when officer was offered a transfer without those duties); *Shelton v. University of Med. & Dentistry of N.J.*, 223 F.3d 220, 226 (3d Cir. 2000) (nurse not entitled to remain in obstetrical unit despite unwillingness to assist with emergency abortions).

HHS misses the mark in insisting (Br. at 42-43) that Title VII's "reasonable accommodation" and "undue hardship" framework has no relevance to the conscience statutes' antidiscrimination provisions because Title VII explicitly incorporates such an affirmative defense in 42 U.S.C. § 2000e(j), while the conscience statutes do not. But courts had already adopted this framework as part of the inherent meaning of "discrimination" even before Congress enacted § 2000e(j). For example, in 1970, the Sixth Circuit held (and the Supreme Court affirmed by an equally divided vote) that an employer does not engage in unlawful discrimination under Title VII by terminating an employee who refused, for religious reasons, to work on Sundays and further refused to find coverage for his Sunday shift as the employer had requested. *See Dewey v. Reynolds Metals Co.*, 429 F.2d 324, 329-30 (6th Cir. 1970), *aff'd*, 402 U.S. 689 (1971).

More fundamentally, nothing in Congress's use of the bare term "discriminate" in the conscience statutes or in the legislative history of those statutes suggests that it intended to displace the common and well-established understanding of what constituted unlawful "discrimination" at the time the statutes were enacted, or to create a unique framework

for discrimination claims based on religious or moral beliefs made by health care providers. To the contrary, concerns about the consequences of accommodating objectors are particularly heightened in the health care context because any harms fall not just on the employer, but also on patients who are themselves entitled to receive needed care. "[P]ublic trust and confidence requires that a public hospital's health care practitioners—with professional ethical obligations to care for the sick and injured—will provide treatment in time of emergency." *Shelton v. University of Med. & Dentistry of N.J.*, 223 F.3d 220, 228 (3d Cir. 2000). Maintaining that public trust is especially critical to the governmental plaintiffs and Amici States alike now, in light of the current health crisis: relationships of trust are critical for ensuring that residents of Amici States and the governmental plaintiffs will seek the medical care they need from local public health care providers. There is no indication in the history of any of the federal conscience statutes that Congress intended its bare use of the word "discrimination" to be less attentive to the greater concerns about undue hardship in the health care context than in the ordinary employment context.

Second, the Rule's broad definition of "discrimination" includes any changes to "employment, title," "position, or status," or "*any* adverse treatment," 45 C.F.R. § 88.2 (discrimination (1), (3)) (emphasis added), regardless of how insignificant such a change may be. That sweeping interpretation is contrary to settled legal principles that employment changes constitute impermissible disparate treatment only if they "materially affect[] the compensation, terms, conditions, or privileges of employment," *Davis v. Team Elec. Co.*, 520 F.3d 1080, 1089 (9th Cir. 2008) (quotation and alteration marks omitted), and must be "more disruptive than a mere inconvenience or an alteration of job responsibilities" that an employee may not like, *Crady v. Liberty Nat'l Bank & Trust Co.,* 993 F.2d 132, 136 (7th Cir. 1993). The D.C. Circuit has applied this principle specifically to the Weldon and Coats-Snowe Amendments, holding that a health care employer would not face liability under these statutes for merely reassigning to another unit an individual who is unwilling to perform an aspect of his job duties based on religious objections—such as by "refus[ing] to provide abortion counseling." *National Family Planning & Reprod. Health Ass'n, Inc. v. Gonzales*, 468 F.3d 826, 829-30 (D.C. Cir. 2006) (rejecting such theory as "anomalous").

As the D.C. Circuit recognized, these conscience statutes' "broadening of the grounds for resisting abortion activity" does not "suddenly transform an accommodating agency's reassignment into an act of discrimination" in the absence of an employment change that would be deemed materially adverse. *Id.* But the Rule would do away with this established antidiscrimination principle as well.

Third, as the California district court observed, the Rule's prohibition against employers even *inquiring* about an applicant's ability and willingness to perform certain medical procedures prior to hiring goes far beyond any existing antidiscrimination prohibitions. (E.R. 55-56.) As HHS has confirmed during past rulemaking, it has never been regarded as unlawful under the conscience statutes (or any other federal antidiscrimination law, including Title VII) for employers "to make rational hiring decisions based on due consideration of an applicant's . . . ability, and desire to perform the essential functions of a job." *See* 73 Fed. Reg. at 78,085.

And courts have long held under Title VII that an employee "has the duty to inform his employer of his religious needs so that the employer has notice of the conflict." *See, e.g.*, *Redmond v. GAF Corp.*, 574 F.2d 897, 902 (7th Cir. 1978). But the Rule simply disregards these

settled principles: it both relieves employees of their longstanding obligation under federal antidiscrimination law to notify employers of a potential conflict, and impermissibly intrudes on the internal affairs of medical employers by arbitrarily limiting employers' ability to know in advance of employees' potential objections so that such objections may be accommodated while ensuring seamless patient care.

By prohibiting employers from requiring advance notice of potential objections that may need to be accommodated, the Rule conflicts with various longstanding state conscience statutes that have long co-existed alongside federal statutes in protecting employees—like those in place in plaintiffs' jurisdictions and some Amici States. *See, e.g.*, N.Y. Civil Rights Law § 79-i(1) (requiring "filing [of] a prior written refusal" of objection); Cal. Health & Safety Code § 123420(a) (requiring "written statement" of objection); Va. Code Ann. § 18.2-75 (same); Wis. Stat. § 253.09(3) (same). Requiring employees to provide clear notice of potential conflicts has long benefited employers and employees alike: such requirements enable employers to plan for accommodations ahead of time, and reduce the likelihood that employees may be asked to perform tasks for which they have conscience objections in the first place.

In sum, the Rule's multiple, stark departures from the well-established understandings of what constitutes unlawful "discrimination" under Title VII and other federal antidiscrimination laws stretch far beyond "the bounds of reasonable interpretation." *See Utility Air Regulatory Grp. v. EPA*, 573 U.S. 302, 321 (2014) (quotation marks omitted). And it does so in ways that are particularly harmful in the health care context by interfering with providers' ability to ensure that patients receive the care that they need, notwithstanding particular individuals' objections to certain medical procedures.

B. The Rule Is Arbitrary and Capricious.

1. The Rule fails to provide a reasoned explanation for HHS's change in position.

The record demonstrates that regulated entities, including Amici States, have had "decades of experience" in effectively discharging their legal obligations under various state and federal conscience statutes while fulfilling their responsibility to ensure patient access to care. (*See, e.g.*, S.E.R. 125, 319-320.) HHS unquestionably and radically upended the longstanding status quo when it promulgated the Rule in 2019. HHS was required under the APA to provide a "detailed justification" for its

departures from these prior positions, and a "reasoned explanation . . . for disregarding facts and circumstances that underlay . . . the prior policy." *See FCC v. Fox Television Stations*, 556 U.S. 502, 515-16 (2009). It failed to do so.

In adopting the Rule's unprecedented definition of "discrimination," however, HHS failed even to "display awareness that it [was] changing position." *See Encino Motorcars*, 136 S. Ct. at 2126 (quotation marks omitted). HHS did not acknowledge its own past statements from 2008 that the federal conscience statutes' prohibition on "discrimination" should be understood by reference to the "significant federal case law" governing discrimination in other contexts, including Title VII. 73 Fed. Reg. at 78,077. Nor did HHS acknowledge its prior guidance, borrowing from that case law, that the federal conscience statutes' prohibition on "discrimination" does not obligate health care employers to hire applicants who are "fundamentally opposed on religious or moral grounds" to performing core job functions in a way that would prevent such employers from ensuring that patients can reliably receive the care that they need. *Id.* at 78,085. HHS's insistence on appeal—that even where there is a "persuasive justification" so as to permit inquiry about an employee's

potential objection, the employer will still be prohibited from taking any employment action based on that inquiry (Br. at 43-44 (quotation marks omitted))—is flatly inconsistent with the agency's own past guidance on the meaning of "discrimination."

Far from "display[ing] awareness" of these prior positions, *Encino Motorcars*, 136 S. Ct. at 2126 (quotation marks omitted), HHS instead suggested that the current Rule changed nothing about compliance obligations. *See* 84 Fed. Reg. at 23,241 (estimating "there would likely not be any costs" for compliance for entities who were already fully compliant with the federal conscience laws prior to the Rule). HHS's failure to acknowledge the significance of the Rule's redefinition of "discrimination," along with its failure to provide the requisite "reasoned explanation" for its dramatic departure from the status quo, supports the Washington district court's conclusion that the Rule is arbitrary and capricious. *See Fox Television Stations*, 556 U.S. at 515.

2. HHS entirely failed to address the substantial reliance interests engendered by the agency's prior policy.

The reliance interests implicated in this case are substantial. The numerous comments contained in the administrative record show that HHS-funded entities have long "shaped their conduct" based on HHS's pre-2019 guidance on the federal conscience statutes in "making hiring decisions, entering into employee contracts and collective bargaining agreements, implementing staffing arrangements, developing . . . practices and policies to accommodate conscience objections, and conducting their general business operations." *See New York*, 414 F. Supp. 3d at 552. These comments amply established that the Rule would upend the entities' long-established policies and practices, and disrupt the effective functioning of the delivery of care. (*See, e.g.*, S.E.R. 322 (hospital association observing the Rule would "make more difficult the process of predicting and planning for scenarios in which conscience rights might need to be exercised" thereby "run[ning] the risk of creating unintended consequences for patient care").)

The record here, however, contains no evidence that HHS gave *any* consideration to the "decades of industry reliance" by plaintiffs and medical employers on the common understandings of the scope of the

federal conscience laws that predated HHS's rulemaking, as the APA requires. *See Encino Motorcars*, 136 S. Ct. at 2126. *See also New York*, 414 F. Supp. 3d at 552-53. Nor does HHS argue to the contrary. *See* Br. at 52-53.

Instead, HHS insists that a party can have "no legitimate reliance interest . . . in an erroneous statutory interpretation." *See id.* at 53. But the Rule did not contend that any of HHS's prior guidance was "erroneous." Indeed, even in this appeal, HHS does not contend that its new reading of the federal conscience statutes is dictated by those statutes' unambiguous meaning; instead, it merely claims that its interpretations "reflect the best reading of the conscience statutes." *Id.* There is thus no basis for HHS to claim that regulated entities relied on "an erroneous statutory interpretation" (*id.*); rather, entities quite reasonably relied on a decades-long understanding of the federal conscience statutes that HHS, to this day, has not disputed was within the agency's interpretive authority.

In any event, the Supreme Court has now made clear that even a credible claim that past agency action was unlawful does not excuse the agency from considering the existence of reliance interests when

undertaking a regulatory change. In *Regents*, the Court rejected the claim that the purported illegality of the Deferred Action for Childhood Arrivals program "automatically preclude[s] reliance interests," and held that the agency was still "required to assess whether there were reliance interests, determine whether they were significant, and weigh any such interests against competing policy concerns." 140 S. Ct. at 1913-15. HHS's failure to do so here renders the Rule invalid.

3. HHS's stated rationales for the Rule are contradicted by the administrative record.

To justify the Rule's sweeping change of the decades-long status quo, HHS claimed that there had been "a significant increase" in complaints since November 2016 "alleging violations of the laws that were the subject of the 2011 Rule," and specifically emphasized that it had received 343 such complaints in fiscal year 2018. *See* 84 Fed. Reg. 23,175, 23,229. HHS also claimed that the 2011 rule had "created confusion over" the obligations imposed by the federal conscience statutes. *Id.* at 23,175.

The record, however, contradicts all of these justifications. The Washington district court thus properly concluded that the Rule was arbitrary and capricious.

On appeal, HHS does not dispute the New York district court's finding (which the Washington court adopted (E.R. 30)) that no more than approximately twenty complaints were even "*potentially* related" to the federal conscience statutes, *see New York*, 414 F. Supp. 3d at 542 (emphasis in original)—nowhere close to the 343 that HHS emphasized during its rulemaking, 84 Fed. Reg. at 23,229, 23,245. *See* Br. at 50-51. HHS nonetheless insists that this Court need not consider the numerical misrepresentations that the agency made in promulgating the Rule because even just twenty complaints in fiscal year 2018 would still "reflect a troubling number of alleged violations" sufficient to justify the Rule. *See id.* at 51. But "[a]n agency must defend its actions based on the reasons it gave when it acted," *Regents*, 140 S. Ct. at 1909, and not on "appellate counsel's *post hoc* rationalizations," *Motor Vehicle Mfrs. Ass'n of U.S. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 50 (1983).

Here, HHS premised its justification for the Rule on having received 343 complaints in fiscal year 2018—not twenty. And the specific number was critical because HHS justified the Rule's significant change to the status quo in large part based on an alleged "significant increase" in conscience-related complaints in fiscal year 2018, 84 Fed. Reg. at

23,229, an increase that, according to HHS, showed growing noncompliance with the federal conscience statutes. Once corrected, however, the record does not support HHS's suggestion that a major departure from the status quo was necessary to address any purportedly substantial new noncompliance.

In any event, viewed in context, in light of HHS's own estimate that the conscience statutes cover somewhere around 500,000 institutions and entities nationwide (and their many staff), *see* 84 Fed. Reg. at 23,235, roughly twenty complaints (accumulated over a twelve-month period) cannot be regarded as a significant number even in the abstract. The number of annual complaints—around twenty across the entire country—is wholly disproportionate to the vast economic costs of the Rule: by HHS's own estimates, regulated entities will incur more than *$150 million* in compliance costs in the first year alone, even assuming that only a fraction of regulated entities proactively undertake compliance efforts. *See id.* at 23,241.

HHS's contention that the increase in complaints was merely "one of the many metrics used to demonstrate the importance of the rule" (Br. at 50 (quotation and alteration marks omitted)) thus ignores the fact that

its empirical claim of an increase in noncompliance was necessary to support its decision to fundamentally alter the regulatory regime enforcing the federal conscience statutes. Absent support for such a claim, "[t]he Rule represents a classic solution in search of a problem." *See New York*, 414 F. Supp. 3d at 546.

Second, notwithstanding HHS's constant refrain that the 2011 rule "created confusion over what is and is not required under Federal conscience" statutes, 84 Fed. Reg. at 23,175, HHS has never identified any concrete evidence in the record demonstrating any confusion on the part of regulated entities arising from the 2011 rule. Nor does the Rule even purport to clarify "how its provisions may or may not interact with other statutes," such as EMTALA and other antidiscrimination laws, so as to resolve any claimed confusion supposedly caused by the 2011 rule as it relates to these other laws. *See id.* at 23,183.

Upon closer examination, what HHS refers to as "confusion" here is simply the view that the federal conscience statutes should be interpreted more broadly than they had been.[9] But a policy preference for expanding

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[9] For instance, HHS cites, as evidence of "confusion," the HHS Office of Civil Rights' 2016 determination to close complaints against

federal conscience protections does not demonstrate any "confusion" warranting the Rule. And if HHS's objective were simply to effect a naked policy change, then it should have said so, rather than providing the "contrived reason[]" that it was addressing confusion that did not actually exist. *See Department of Commerce v. New York*, 139 S. Ct. 2551, 2576 (2019); *see also id.* at 2575 (vacating agency action due to "significant mismatch between the decision the Secretary made and the rationale he provided").

California based on the agency's prior interpretations of the Weldon Amendment—interpretations that HHS criticized in 2019 as "unduly narrow." *See* 84 Fed. Reg. at 23,178-79.

CONCLUSION

This Court should affirm the judgments of the district courts below.

Dated: New York, New York
October 20, 2020

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