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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COUNTY OF SANTA CLARA, TRUST WOMEN SEATTLE, LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, CENTER ON HALSTED, HARTFORD GYN CENTER, MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

Case No. 5:19-cv-2916

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

INTRODUCTION

1. When people go to an emergency room, clinic, or public health program seeking treatment for illness or injury, they expect and trust that they will receive care appropriate to meet their health needs, without regard to their sex, gender identity, sexual orientation, disability status, or religion, or the type of healthcare they seek. Healthcare providers have adopted nuanced policies that respect healthcare workers' religious and moral beliefs; protect patients' access to information and timely, high-quality care; and satisfy healthcare providers' legal and professional duties of care to all patients.

2. Now, however, the U.S. Department of Health and Human Services has issued a new regulation (the "Denial-of-Care Rule") that upsets this thoughtful approach. Although purporting to implement long-standing healthcare statutes with specific provisions affording protections for the religious or moral beliefs of certain individuals and entities ("religious objections"), the Rule instead creates a wholly new regime that elevates religious objections over all other interests and values. The Rule invites a much larger universe of healthcare workers to decline to serve patients based on religious objections, defines with unprecedented breadth the types of activities to which they may object, and fails to reconcile objections with the needs and rights of patients—even though doing so is critical in any regulatory scheme administering these laws. And the Rule does not include emergency exceptions. As a result, the Rule endangers patients' health in the name of advancing the religious beliefs of those who are entrusted with caring for them—a result sharply at odds with the stated mission of the Department of Health and Human Services ("HHS"), which is to "enhance and protect the health and well-being of all Americans" and to "provid[e] for effective health and human services."

3. The Rule applies to hospitals, medical schools, public- and community-health programs, and state and local governments throughout the Nation that are recipients or subrecipients of certain federal funds. These healthcare providers must comply with the Rule or risk incurring draconian penalties, including the withdrawal or clawback of all federal funding. Yet the Rule offers scant guidance on how healthcare providers might satisfy the Rule's extreme obligations while still reliably delivering patient care. And the Rule places vague and unworkable

limits on the reasonable measures that are necessary to protect patients (and comply with the applicable standards of care and medical ethics) when accommodating objections. By failing to provide for emergency exceptions or to address an array of other issues about the Rule's requirements, the agency's action leaves healthcare providers utterly in the dark about what they may or may not do to protect patients consistent with the Rule. If they guess wrong, they could lose federal funding, which would frustrate their ability to provide adequate care to their most needy patients.

4. The Rule specifically invites refusals to provide care to women seeking reproductive healthcare and transgender and gender-nonconforming patients seeking gender-affirming care, adversely affecting the healthcare entities that provide reproductive healthcare services and that serve the lesbian, gay, bisexual, and transgender ("LGBT") community. The Rule stigmatizes and shames these patients, depriving them of their constitutionally protected rights of access to healthcare and their dignity and autonomy in seeking medically necessary healthcare central to their self-determination. The Rule will delay and deny the provision of care and information to many patients. It also will deter patients from disclosing their medical histories, gender identities, or transgender status as they seek care; chill patients from expressing themselves in a manner consistent with their gender identities; and render them less likely to seek healthcare services at all, detrimentally affecting not only individual patients' mental and physical health, but public health generally.

5. In adopting the Rule, HHS acted arbitrarily and capriciously, in excess of its statutory authority, and in conflict with other laws. Among other problems, HHS failed adequately to consider significant factors, including the Rule's lack of workability and its impact on patients, despite numerous comments raising these concerns; it defined key statutory terms in a manner that is contrary to the underlying statutes; and it ignored limitations contained in other federal laws on HHS's authority to limit patient access to information and care, including emergency care.

6. The Rule infringes the constitutional rights of patients by impermissibly advancing the religious beliefs of individual employees over the constitutional rights of patients, including patients' rights to liberty and privacy guaranteed by the Fifth Amendment; their right to equal

protection of the laws; and their rights to free speech and expression. The Rule also infringes the constitutional rights of healthcare providers and their patients not to be compelled by the government to live and act in accordance with religious beliefs to which they do not subscribe.

7. The Rule is ill-considered and dangerous, and it puts us all at risk. It should be declared unlawful and enjoined.

JURISDICTION AND VENUE

8. This Court has jurisdiction under 28 U.S.C. § 1331, as this case arises under the United States Constitution and the Administrative Procedure Act, 5 U.S.C. § 701 *et seq.*, and challenges final agency action for which there is no other adequate remedy, 5 U.S.C. § 704.

9. The Court has the authority to issue declaratory and injunctive relief under the Declaratory Judgment Act, 28 U.S.C. § 2201 *et seq.*, and the Administrative Procedure Act, 5 U.S.C. § 701 *et seq.*

10. Defendants are subject to suit in any federal jurisdiction in challenges to federal regulations, and no real property is involved in this action. 42 U.S.C. §1391(e)(1).

11. Venue is proper in the Northern District of California under 28 U.S.C. § 1391(b) and (e)(1) because at least one Plaintiff resides in this district and each defendant is an agency of the United States or an officer of the United States sued in his or her official capacity.

12. The challenged Rule is final and subject to judicial review under 5 U.S.C. §§ 702, 704, and 706.

PARTIES

A. Plaintiffs

13. Plaintiffs include a governmental entity that owns healthcare facilities (the County of Santa Clara); five private healthcare facilities that provide reproductive-health services and healthcare services for LGBT individuals (Trust Women Seattle, the Los Angeles LGBT Center, Whitman-Walker Clinic, Inc. d/b/a Whitman-Walker Health, Hartford Gyn Center, and Mazzoni Center) ("private-healthcare-provider Plaintiffs"); four individual physicians and a licensed counselor who work for these entities ("individual-provider Plaintiffs"); three national associations of medical professionals (Medical Students for Choice, AGLP: Association of LGBTQ

Psychiatrists, and American Association of Physicians for Human Rights d/b/a GLMA: Health Professionals Advancing LGBTQ Equality) ("medical-association Plaintiffs"); and two organizations that provide a wide range of services to the LGBT community (Bradbury-Sullivan LGBT Community Center and Center on Halsted) ("LGBT-services Plaintiffs").

14. The private-healthcare-provider and individual-provider Plaintiffs assert claims on their own behalf and also on behalf of their patients and recipients of services, who face barriers to asserting their own claims and protecting their own interests. The medical-association Plaintiffs assert claims on behalf of themselves and their members.

15. Plaintiffs assert different but complementary interests, and share the common objective of maintaining an effective, functioning healthcare system, one that protects patients' dignity and their rights of access to health services as well as the dignity of healthcare workers who raise religious objections. Plaintiffs also support the objective of providing informed access to comprehensive reproductive healthcare and gender-affirming and medically appropriate care to transgender and gender-nonconforming patients without discrimination based on a patient's sex, gender identity, or transgender status and in accordance with medical and ethical standards of care.

16. Plaintiff **County of Santa Clara** is a charter county and political subdivision of the State of California, located in the Northern District of California. It is home to almost two million residents, is more populous than 14 States, and employs more than 20,000 people.

17. The County, as part of its governmental responsibilities, is tasked with providing critical safety-net and public health services. These core County functions are undertaken by a network of County departments and programs, including several County-owned and -operated hospitals, public pharmacies, a public health department, an emergency-medical-services department, a behavioral-health-services department, and a publicly run health-insurance plan. The County of Santa Clara Health System is the only public safety-net healthcare provider in Santa Clara County, and it is the second largest such provider in the State of California.

18. To operate this network, and because of the County's focus on serving indigent and vulnerable populations whose insurance is paid through federally funded Medicare or Medicaid, the County is dependent on hundreds of millions of dollars of federal funding from HHS. The

County also receives funding through a variety of other funding streams that pass through HHS, including under the Public Health Services Act ("PHSA"). Because it receives this federal funding, the County is subject to the Denial-of-Care Rule in its entirety.

19. At the center of the County's health system are the County's three hospitals. The County owns and operates Santa Clara Valley Medical Center ("Valley Medical Center"), an acute-care hospital with over 6,000 employees providing emergency medical services, primary care, hospital care, and reproductive-health services. The mission of Valley Medical Center and its satellite clinics is to provide high-quality, accessible, and compassionate care to all, regardless of their socio-economic status or ability to pay. Last year, Valley Medical Center had an average daily census of 363 patients and handled 3,087 births and 88,856 emergency department visits.

20. Valley Medical Center also operates a Gender Health Center that provides (1) resources and psychological support for people of all ages, including children, teens, and young adults, who seek to understand and explore their gender identity; (2) medical care, including hormone treatments; and (3) primary care, including HIV and STI testing. Patient services at the Gender Health Center include standard primary care and acute care, as well as specialized care for the psychological and biological elements of gender transition. Valley Medical Center also operates a family-planning clinic, which provides contraception and abortion services, and it operates a dedicated clinic for LGBT patients.

21. In March 2019, the County purchased three additional major health facilities in danger of closing—O'Connor Hospital, St. Louise Regional Hospital, and De Paul Health Center—adding these critical local facilities to its safety net. O'Connor Hospital is the home of one of the only family-medicine residency programs in the Bay Area. It provides emergency medical services, urgent-care services, primary care, hospital care, and reproductive-health services. Last year, O'Connor Hospital handled an estimated 51,948 emergency visits, 4,311 surgical cases, and 1,631 births.

22. St. Louise Regional Hospital, located in the City of Gilroy, operates the only acute-care hospital in the southern part of Santa Clara County and specializes in maternal child-health services, emergency services, women's health, breast-cancer care, imaging, surgical procedures,

and wound care. St. Louise Regional Hospital is the only hospital in reasonable proximity to many County residents living in the vast rural areas to the north, east, and south of the City of Gilroy.

23. De Paul Health Center, located in the City of Morgan Hill, provides urgent-care services and a breast cancer clinic, and is also one of the key healthcare clinics close to many of the rural residents in the County. In 2018, De Paul Health Center provided care for approximately 8,858 patients.

24. The County also operates the local public health department, which is responsible for providing immunizations; tracking disease outbreaks; offering long-term case management for patients with conditions such as active tuberculosis; providing testing, prevention, and treatment services for sexually transmitted diseases; operating a needle-exchange program; and planning for health emergencies. The 15 cities within the County—including the City of San José, the nation's tenth largest city—lack their own public health departments and depend on the County to provide all public health services.

25. To support its hospitals and public health department, the County operates numerous pharmacies that supply essential medicines and treatments, including those used for contraceptive care, abortions, hormone therapy as part of gender-transition-related care, sexually transmitted infections, and HIV/AIDS. One County pharmacy provides free, donated medicine to individuals who cannot afford the retail cost of needed medications. Another specializes in serving patients with HIV/AIDS, patients with tuberculosis, patients from the Public Health Department's STD clinic, and patients being discharged from the County jail. Staff at these pharmacies supports communicable-disease control by procuring, storing, maintaining, and distributing essential medications and vaccines during outbreaks and by distributing state-funded influenza vaccines for administration at no charge to low-income and elderly residents.

26. The County also operates the local emergency-medical-services system, overseeing all 911 ambulance response countywide. The County is also the sole accreditor in the county for emergency responders, such as ambulance workers and firefighters.

27. The Santa Clara County Behavioral Health Services Department serves County residents in need of mental-health and substance-use-treatment services. It provides needed

emergency and crisis care, short-term and long-term inpatient psychiatric care, outpatient mental-health care, medication support, case-management services, and substance-abuse treatment. These services are provided to many County residents from vulnerable populations, with a focus on providing non-stigmatizing care to support those affected by mental illness and substance use.

28. The County also operates the only local publicly operated insurance plan, Valley Health Plan. As a health-maintenance organization, Valley Health Plan offers various healthcare-coverage plans that give enrolled members access to a range of medical services from physicians and other healthcare providers within Valley Health Plan's network.

29. Plaintiff **Trust Women Seattle**, located in Seattle, Washington, is a clinic that provides full-spectrum reproductive-health services, including abortion and transgender-health services. Its mission is to expand access to abortion, healthcare for LGBT people, and reproductive healthcare in underserved communities throughout the United States. In serving this mission, Trust Women strives to treat all patients with dignity and compassion. Trust Women Seattle is a subrecipient of federal Medicaid funding through the State of Washington and therefore is subject to the Denial-of-Care Rule.

30. Plaintiff **Dr. Colleen McNicholas** is the Medical Director for Trust Women, overseeing medical practice at Trust Women's Seattle, Oklahoma, and Kansas clinics. Dr. McNicholas is involved in all aspects of medical decision-making with respect to abortion, contraception, and transgender care offered at Trust Women Seattle. She provides full-spectrum reproductive healthcare to her patients, including contraceptive care and abortion care into the second trimester. In her hospital practice, Dr. McNicholas has developed a program to incorporate gender-affirming gynecologic treatment for transgender children and adults. And she trains other providers to provide abortion, contraception, and gender-affirming care. Dr. McNicholas is the Director of the Ryan Residency Collaborative between Oklahoma University and Washington University School of Medicine in St. Louis, Missouri, which offers formal training in abortion and family planning to residents in obstetrics/gynecology; the Assistant Director of the Fellowship in Family Planning at Washington University School of Medicine; and an Associate Professor at

Washington University School of Medicine, in the Department of Obstetrics and Gynecology's Division of Family Planning.

31. Plaintiff **Los Angeles LGBT Center** is located in Los Angeles, California. Its mission is to build a world in which LGBT people thrive as healthy, equal, and complete members of society. The LA LGBT Center offers programs, services, and advocacy spanning four broad categories: health, social services and housing, culture and education, and leadership and advocacy. The LA LGBT Center has more than 650 employees and provides services for more LGBT people than any other organization in the world, with about 500,000 patient visits per year. LA LGBT Center receives funds under the PHSA. Approximately 80 percent of the LA LGBT Center's funding originates from the federal government, including, but not limited to, funding under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, 42 U.S.C. § 300ff *et seq.* ("Ryan White funding"); direct funding from the Centers for Disease Control and Prevention, discounts under the 340B Drug Discount Program, grants under section 330 of the PHSA; grants from HHS-HRSA-Bureau of Primary Health Care under which the LA LGBT Center is a Federally Qualified Health Center; and Medicaid and Medicare reimbursements. The LA LGBT Center therefore is subject to the Denial-of-Care Rule.

32. Plaintiff **Dr. Robert Bolan** is the Chief Medical Officer of the LA LGBT Center. He oversees the delivery of healthcare for approximately 9,000 patients who come to the LA LGBT Center and personally treats approximately 300 patients. Over 90% of these patients identify as LGBT, many of them coming from different areas of California and other States to obtain services in a safe and affirming environment. Dr. Bolan also oversees the LA LGBT Center's Research Department. Dr. Bolan and the providers he supervises treat patients who identify as transgender and who require gender-affirming treatment, including medically necessary healthcare for gender dysphoria. Many of Dr. Bolan's patients and many of the patients of the providers he supervises at the LA LGBT Center already have experienced traumatic and discriminatory denials of healthcare based on their sexual orientation, gender identity, transgender status, or HIV status at the hands of providers outside the LA LGBT Center, including by healthcare providers who have expressed

religious or moral objections to treating them. Such experiences will increase as a result of the Denial-of-Care Rule.

33. Plaintiff **Dr. Ward Carpenter** is the Co-Director of Health Services at the LA LGBT Center. Dr. Carpenter is a nationally recognized expert in the field of transgender medicine. In his role as Co-Director of Health Services, Dr. Carpenter oversees the healthcare of over 17,000 patients who come to the LA LGBT Center and personally treats 150 patients. All of Dr. Carpenter's patients identify within the LGBT community, and approximately 30% of them are people living with HIV. These patients come from different areas of California and other States to obtain services in a safe and affirming environment. Dr. Carpenter's patient population is disproportionately low-income and experiences high rates of chronic medical conditions, homelessness, unstable housing, and extensive trauma history. In addition, many of Dr. Carpenter's patients, as well as those of the other medical providers he supervises at the Center, already have experienced traumatic and discriminatory denials of healthcare based on their sexual orientation, gender identity, transgender status, or HIV status at the hands of providers outside the LA LGBT Center, including by healthcare providers who have expressed religious or moral objections to treating them. Such experiences will increase as a result of the Denial-of-Care Rule.

34. Plaintiff **Whitman-Walker Clinic, Inc. d/b/a Whitman-Walker Health**, located in Washington, D.C., provides a range of services, including medical and community healthcare, transgender care and services, behavioral-health services, dental-health services, legal services, insurance-navigation services, and youth and family support. It has particular expertise in LGBT and HIV care. The mission of Whitman-Walker is to offer affirming community-based health and wellness services to all with a special expertise in LGBT and HIV care. Whitman-Walker empowers all persons to live healthy, love openly, and achieve equality and inclusion. In 2018, Whitman-Walker provided health care services to more than 20,700 individuals. Whitman-Walker receives various forms of federal funding from HHS and from institutions affiliated with or themselves funded by HHS, including but not limited to funds under the PHSA, direct grants, Ryan White funding, funds under the 340b drug subsidy program, research grants from the Centers for Disease Control and Prevention and the National Institutes of Health, and Medicaid and Medicare

reimbursements. For 2019, Whitman-Walker's federally funded research contracts and grants total more than $2 million. Whitman-Walker therefore is subject to the Denial-of-Care Rule.

35. Plaintiff **Dr. Sarah Henn** is the Chief Health Officer of Whitman-Walker. Dr. Henn oversees all healthcare-related services at Whitman-Walker and maintains a panel of patients for whom she provides direct care. Whitman-Walker's patient population, including patients to whom Dr. Henn provides direct care and whose care she oversees, includes many patients who have experienced refusals of healthcare or who have been subjected to disapproval, disrespect, or hostility from medical providers outside of Whitman-Walker because of their actual or perceived sexual orientation, gender identity, or transgender status. Many of Dr. Henn's patients and those whose care she oversees are, therefore, apprehensive or fearful of encountering stigma and discrimination in healthcare settings because of their past experiences. Such experiences will increase as a result of the Denial-of-Care Rule. In addition to overseeing medical care of patients and working with her own patients, Dr. Henn oversees Whitman-Walker's Research Department, and is personally involved in a number of clinical research projects, including as the Leader of Whitman-Walker's Clinical Research Site for the AIDS Clinical Trials Group funded by the National Institutes of Health.

36. Plaintiff **Dr. Randy Pumphrey** is Senior Director of Behavioral Health at Whitman-Walker. As Senior Director of Behavioral Health, Dr. Pumphrey oversees Whitman-Walker's portfolio of mental-health services and substance-use-disorder-treatment services and maintains a panel of patients for whom he provides direct behavioral healthcare. In 2018, Whitman-Walker provided mental-health or substance-use-disorder-treatment services to over 2,300 patients, many of whom identify as LGBT or are living with HIV. Many, if not most, of the patients to whom Dr. Pumphrey provides direct care and whose behavioral healthcare he oversees face considerable stigma and discrimination as people living with HIV, as sexual or gender minorities, or as people of color and have experienced difficulty finding therapists or other mental-health or substance-use-disorder professionals who are understanding and welcoming of their sexual orientation, gender identity, or transgender status. Such experiences of discrimination will increase as a result of the Denial-of-Care Rule.

37. Plaintiff **Center on Halsted** is a 501(c)(3) nonprofit organization based in Chicago and incorporated in Illinois. Center on Halsted is a comprehensive community center dedicated to securing the health and well-being of the LGBT people of the Chicago area. Center on Halsted provides programs and services for the LGBT community, including HIV/HCV testing; behavioral health services; case management, job development, social programming, meals, and housing for seniors; housing, meals, counseling, and leadership for youth; and anti-violence services. Center on Halsted also administers social programming for families and advises patrons on concerns related to family planning. On average, more than 1400 community members visit Center on Halsted each day. Center on Halsted receives various forms of pass-through federal funding from HHS, including Ryan White funding and funding from the National Institutes of Health and the Centers for Disease Control and Prevention. Center on Halsted also benefits from programs governed by the Centers for Medicare through Medicare reimbursements.

38. Plaintiff **Hartford Gyn Center**, located in Hartford, Connecticut, is the only independent, state-licensed family-planning clinic in Connecticut. Hartford Gyn Center provides reproductive-health services, including contraception and abortion services through 21 weeks. Hartford Gyn Center's mission is to provide women with compassionate reproductive-health services and abortion care, to respect the autonomy of each patient, to support and strengthen reproductive rights, and to effect corresponding social change. Hartford Gyn Center sees patients from all walks of life, including low-income patients who cannot easily access care elsewhere, if at all. Hartford Gyn is one of the only facilities in the region that trains physicians in abortion care, especially in the second trimester. The clinic also operates a medical-residency and training program. Hartford Gyn Center is a subrecipient of federal Medicaid funding through the State of Connecticut and therefore is subject to the Denial-of-Care Rule.

39. Plaintiff **Bradbury-Sullivan LGBT Community Center** is a 501(c)(3) nonprofit organization based in Allentown, Pennsylvania, and incorporated in Pennsylvania. It is dedicated to securing the health and well-being of LGBTQ people of the Greater Lehigh Valley. It provides a variety of programs and services for the LGBTQ community, including HIV/STI testing, healthcare-enrollment events, family-planning services, support groups, and a free legal clinic.

Bradbury-Sullivan Center also provides referrals to LGBT-welcoming healthcare providers, including providers engaged in family planning services. Patrons of Bradbury-Sullivan Center often seek healthcare services from other healthcare organizations, including religiously affiliated organizations. Bradbury-Sullivan Center works with patrons who have experienced discriminatory treatment when seeking healthcare services from such organizations and it advocates on behalf of those patrons by providing referrals to LGBT-welcoming agencies and providers, training agencies to provide LGBT-welcoming services, and, when necessary, communicating with agencies to inform them of their legal obligations to serve LGBT people. Bradbury-Sullivan Center also conducts research documenting health disparities in the LGBT community and performs related community-education efforts to improve public health within the LGBT community. Bradbury-Sullivan Center receives pass-through funding from HHS through the Maternal and Child Health Services Block Grant, and in the past also has received Ryan White funding. Bradbury-Sullivan Center therefore is subject to the Denial-of-Care Rule.

40. Plaintiff **Mazzoni Center**, located in Philadelphia, Pennsylvania, is a multi-service, community-based healthcare and social-service provider that primarily serves LGBTQ individuals and individuals living with HIV. Its mission is to provide quality comprehensive health and wellness services in an LGBTQ-focused environment, while preserving the dignity and improving the quality of life of the individuals whom it serves. Mazzoni Center receives various forms of federal funding, including Title X Family Planning, Centers for Disease Control, Department of Justice, and Ryan White funding. Mazzoni Center therefore is subject to the Denial-of-Care Rule.

41. Plaintiff **American Association Of Physicians For Human Rights d/b/a GLMA: Health Professionals Advancing LGBT Equality** (formerly known as the Gay & Lesbian Medical Association) is a 501(c)(3) nonprofit membership organization based in Washington, D.C., and incorporated in California. GLMA is a national organization committed to ensuring health equity for lesbian, gay, bisexual, transgender, queer, and all sexual and gender minority individuals, and equality for health professionals in such communities in their work and learning environments. To achieve this mission, GLMA utilizes the scientific expertise of its diverse multidisciplinary membership to inform and drive advocacy, education, and research. GLMA represents the interests

of tens of thousands of LGBTQ health professionals and millions of LGBTQ patients and families across the United States. GLMA's membership includes approximately 1,000 member physicians, nurses, advanced-practice nurses, physician assistants, researchers and academics, behavioral-health specialists, health-profession students, and other health professionals throughout the country. Their practices represent the major healthcare disciplines and a wide range of health specialties, including internal medicine, family practice, psychiatry, pediatrics, obstetrics/gynecology, emergency medicine, neurology, and infectious diseases.

42. Plaintiff **Medical Students for Choice** is a 501(c)(3) nonprofit organization based in Philadelphia, Pennsylvania. MSFC provides training in the provision of abortion services to medical students and residents throughout the country, works to destigmatize abortion provision, and advocates for medical schools and residency programs to include abortion as part of the reproductive-health-services curriculum. MSFC's members include 163 chapters of medical students and residents at medical schools in 45 States. MSFC has thousands of medical-student members and thousands of alumni who are practicing physicians.

43. Medical students receive their clinical training disproportionally at academic medical centers and teaching hospitals that receive significant federal funding. Likewise, residents are almost entirely subsidized through federal funding from HHS, including through Medicare grants. Residents receive salaries that are directly funded by Medicare, and hospitals bill Medicare for services provided to patients by residents. MSFC guides student and resident members in how to obtain abortion training and runs a reproductive-health externship program that places members in abortion clinics for training. MSFC also runs its own educational programs, including a competitive 400-student training institute taught by alumni. Because of resource constraints, the institute is already limited to accepting fewer than half the students who apply for the program.

44. Many of MSFC's members receive various forms of federal funding directly or indirectly via federal programs. MSFC's members are, thus, subject to the restrictions of the Denial-of-Care Rule. Without federal funding, MSFC members may not have the resources to provide proper treatment to their patients and have a reasonable fear that they could be sanctioned and lose federal funding for providing and training others to provide abortion.

45. Through its student and resident members across the country and its alumni who are practicing physicians at hospitals and clinics, MSFC is aware that many hospitals, healthcare facilities, and educational programs no longer provide abortion care or training. Because the Denial-of-Care Rule creates strong incentives for even more healthcare institutions to cease providing abortion training (including by putting at risk federal funding for those institutions that provide such training), the Rule will further strain MSFC's resources and threaten its mission of ensuring that doctors receive training in abortions and abortion-related care.

46. Plaintiff **AGLP: The Association of LGBTQ Psychiatrists** is a 501(c)(3) nonprofit organization based in Philadelphia, Pennsylvania. AGLP, the oldest association of LGBTQ+ professionals in the country, is a national organization of psychiatrists that educates and advocates on LGBTQ mental-health issues. AGLP represents the interests of 450 LGBTQ+ psychiatrists throughout the country who are members of the Association, and works to influence policies relevant to the LGBTQ+ community, as well as to support its members and advocate for its members' patients. AGLP also assists medical students and residents in their professional development; encourages and facilitates the presentation of programs and publications relevant to LGBTQ concerns at professional meetings; and serves as liaison with other minority and advocacy groups within the psychiatric community. Many of AGLP's members receive various forms of federal funding directly or indirectly via federal programs. AGLP's members therefore are subject to the restrictions of the Denial-of-Care Rule. Without federal funding, AGLP members may not have the resources to provide proper treatment to their patients or proceed with their medical-research programs. AGLP's members, therefore, have a reasonable fear that they could be sanctioned and lose federal funding for the work that they do in enforcing nondiscrimination policies and ensuring patient care in accordance with medical standards of care and ethical requirements, which are vital to providing proper care to patients.

B. Defendants

47. Defendant **HHS** is a cabinet department of the federal government, headquartered in the District of Columbia. It has responsibility for, among other things, enhancing and protecting Americans' health and well-being via the provision of health and human services.

48. Defendant **Alex M. Azar, II** is the Secretary of HHS and is sued in his official capacity. Secretary Azar is responsible for all aspects of the operation and management of HHS, including the adoption, administration, and enforcement of the Denial-of-Care Rule.

STATEMENT OF FACTS

A. Statutory Background

49. A network of federal statutes mandates nondiscriminatory treatment of patients and healthcare workers. Some statutes mandate that patients receive nondiscriminatory access to healthcare, information about treatment options, and emergency services. Other statutes allow individuals or entities to object to participating in certain medical procedures on religious or moral grounds and prohibit discrimination against them. These statutes, together with the patients' constitutional rights and healthcare providers' duties of care and ethical obligations, require healthcare providers to accommodate religious objections in a manner that does not interfere with the delivery of services or information to patients.

1. Laws Protecting Patients' Access to Care and Information

50. Congress has repeatedly recognized the paramount importance of providing patients with prompt and nondiscriminatory access to medical care and to information about all treatment options.

51. For example, Section 1554 of the Patient Protection and Affordable Care Act (ACA) provides that "[n]otwithstanding any other provision of this Act, the Secretary of Health and Human Services shall not promulgate any regulation that—

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

> (6) limits the availability of healthcare treatment for the full duration of a patient's medical needs."

42 U.S.C. § 18114.

52. Section 1557 of the ACA, 42 U.S.C. § 18116, similarly protects against discrimination in the provision of healthcare services. It provides: "[A]n individual shall not, on [a] ground prohibited under title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or section 504 of the Rehabilitation Act of 1973, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance." This provision therefore prohibits discrimination based on sex, including discrimination based on a patient's failure to conform to sex stereotypes, gender identity, or transgender status, all of which are forms of sex discrimination.

53. The Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd(b)(1) ("EMTALA") governs when and how a patient must be examined and offered treatment (including medically necessary abortion services) while in an unstable medical condition. It requires a hospital that "determines that [an] individual has an emergency medical condition" to "provide either—(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or (B) for transfer of the individual to another medical facility . . . ." *Id.*

54. The ACA, which respects certain religious objections to healthcare procedures, makes clear that nothing in it may "be construed to relieve any healthcare provider from providing emergency services as required by State or Federal law," including EMTALA. 42 U.S.C. § 18023(d).

55. Title X of the Public Health Service Act, 42 U.S.C. §§ 300-300a-6, provides federal funding for family-planning services. Congress requires Title X grantees to operate "voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services." 42 U.S.C. § 300(a). Title X appropriations bills, *e.g.*, 2019 Continuing Appropriations Act, Pub. L. No. 115-245, Div. B., Tit. II, 132 Stat. 2981, 3070-71 (2018), require

that "all pregnancy counseling shall be nondirective"; in other words, funded projects are to offer pregnant women neutral, nonjudgmental information and counseling regarding their options, including prenatal care and delivery; infant care, foster care, or adoption; and pregnancy termination.

2. Laws Protecting Religious Objectors

56. Certain statutes applicable to recipients of federal funds allow individuals to opt out of participating in certain medical procedures, training, or research based on their religious beliefs or moral convictions, and prohibit discrimination against individuals or entities for asserting such objections. These laws include, among others, the Weldon Amendment, *e.g.*, Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019, Pub. L. 115-245, § 507(d)(2), 132 Stat. 2981, 3118 (2018); the Coats-Snowe Amendment, 42 U.S.C. § 238n; and the Church Amendments, 42 U.S.C. § 300a-7.

57. The Weldon Amendment is a rider that has been attached to the Labor, Health, and Human Services, and Education, and Related Agencies Appropriations Act every year since 2004. 162 Cong. Rec. H4844, H4852 (July 13, 2016) (Rep. Weldon). It provides that none of the funds appropriated under that Act "may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual healthcare entity to discrimination on the basis that the healthcare entity does not provide, pay for, provide coverage of, or refer for abortions." Pub. L. 115-245, § 507(d)(2), 132 Stat. 2981, 3118 (2018).

58. The Coats-Snowe Amendment prohibits abortion-related governmental discrimination in the area of medical training. It provides that "[t]he federal government, and any state or local government that receives Federal financial assistance," may not discriminate against a healthcare entity because "the entity refuses to undergo training in the performance of induced abortions, to require or provide such training, to perform such abortions, or to provide referrals for such training or such abortions," 42 U.S.C. § 238n(a)(1); "refuses to make arrangements" for those

activities, *id.* § 238n(a)(2); or attends or attended a program that does not perform abortions or provide training in abortion care, *id.* § 238n(a)(3).

59. The Church Amendments, which were adopted in the 1970s, provide certain protections for religious and moral objections arising in medical research and training. One subsection provides that the receipt of certain federal funds by a healthcare provider does not authorize "any court or any public official or other public authority" to require an individual to perform or assist in the performance of an abortion or sterilization procedure, or to require an entity to make its facilities or personnel available for those procedures. 42 U.S.C. § 300a-7(b). Another subsection provides that an entity receiving federal funding for biomedical or behavioral research may not discriminate against personnel on the basis that they refused on religious or moral grounds to participate in a research or healthcare activity. 42 U.S.C. § 300a-7(c). A third subsection provides that an entity receiving certain federal funds may not discriminate against a physician or health care personnel in employment, promotion, termination, or the extension of staff or other privileges because he performed or refused to perform or assist in the performance of an abortion or sterilization procedure on the grounds that it would be contrary to his religious beliefs or moral convictions. 42 U.S.C. § 300a-7(c)(1). A fourth subsection prohibits discrimination by certain funding recipients against applicants for training or study based on their "reluctance, or willingness, to counsel, suggest, recommend, assist, or in any way participate in abortions or sterilizations" because of "the applicant's religious beliefs or moral convictions." 42 U.S.C. § 300a-7(e).

60. Subsection (d) of the Church Amendments provides that "[n]o individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions." 42 U.S.C. § 300a-7(d).

61. The ACA prohibits discrimination by any recipient of federal funds against persons or entities because of their refusal to cause or assist in suicide or euthanasia, 42 U.S.C. § 18113; provides that the ACA does not require a health-insurance plan to provide coverage for abortions, 42 U.S.C. § 18023(b)(1)(A); prohibits any "qualified health plan offered through an [Insurance]

Exchange" from "discriminat[ing] against any individual healthcare provider or facility because" it does not "provide, pay for, provide coverage of, or refer for abortions," 42 U.S.C. § 18023(b)(4); and states that the ACA should not be construed to affect other federal laws regarding "conscience protection" or willingness or refusal to provide abortions, 42 U.S.C. § 18023(c)(2)(A)(i)-(iii).

62. Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e *et seq.*, prohibits discrimination against employees based on their religious beliefs and requires accommodation of religious practices. Importantly, employers' ability to ensure reliable care for their patients is recognized as a "business necessity," 42 U.S.C. § 2000e-2(k)(1)(A)(i), and religious accommodation is required only if, and only to the extent that, it does not create "undue hardship," 42 U.S.C. § 2000e(j).

3. The Implementation and Enforcement of Religious-Objection Laws

63. The religious-objection laws described above are self-executing and do not require regulations to go into effect. Accordingly, healthcare providers covered by the laws, including both the County and the private-healthcare-provider Plaintiffs, have adopted policies that accommodate conscience interests without compromising patients' access to care and information.

64. Nevertheless, HHS previously promulgated regulations purporting to clarify and implement the religious-objection laws. On December 19, 2008, more than nine years before it proposed the Denial-of-Care Rule, HHS promulgated a final rule that purported to implement the Church Amendments, the Weldon Amendment, and the Coates-Snowe Amendment. *See* Ensuring That Dep't of Health & Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 78,072 (Dec. 19, 2008). On January 20, 2009, the final rule went into effect.

65. On March 10, 2009, HHS proposed to rescind the January 2009 rule in its entirety. It noted that no statutory provision required promulgation of regulations and that commenters had raised numerous questions and concerns about the regulations. *See* Rescission of the Regulation Entitled "Ensuring That Dep't of Health & Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law"; Proposal, 74 Fed. Reg. 10,207 (Mar. 10, 2009).

66. On February 23, 2011, HHS largely rescinded the regulations but retained provisions delegating to HHS's Office for Civil Rights ("OCR") the authority to receive complaints of violations of religious-objection laws. *See* Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws, 76 Fed. Reg. 9968 (Feb. 3, 2011).

67. The Rule challenged in this action is a centerpiece of the Trump Administration's concerted, aggressive effort to expand enforcement of religious-objection laws at the expense of patients. On January 18, 2018, the Acting Secretary of HHS established a new Conscience and Religious Freedom Division within OCR and delegated to this new Division the responsibility to enforce religious-objection laws. OCR then increased the budget of the Conscience and Religious Freedom division by $1.546 million. OCR also modified its mission statement to emphasize a commitment to enforce "federal laws that guarantee the protection of conscience and free exercise of religion and prohibit coercion and religious discrimination in HHS-conducted or funded programs." When it promulgated the final Denial-of-Care Rule, HHS emphasized OCR's "singular and critical responsibility . . . to vigorously enforce" federal conscience laws. *See* Protecting Statutory Conscience Rights in Health Care, 84 Fed. Reg. 23,170, 23,178 (May 21, 2019) (to be codified at 45 C.F.R. Pt. 88).

C. The Proposed Denial-of-Care Rule

68. On January 26, 2018, the Acting Secretary proposed the Denial-of-Care Rule. *See* Protecting Statutory Conscience Rights in Health Care; Delegation of Authority, 83 Fed. Reg. 3880 (Jan. 28, 2018). The proposed Rule, like the final Rule, adopted an expansive construction of the religious-objection laws; ignored healthcare providers' obligations to ensure their patients' uninterrupted access to care and information and to advance the providers' own missions as healthcare institutions; imposed costly certification and recordkeeping requirements; would undermine Plaintiffs' ability to fulfill their missions; would require healthcare providers to rewrite and re-conceptualize their existing religious-objection policies; and threatened draconian penalties for violations without providing sufficient guidance on how to comply with the Rule.

69. During the 60-day notice-and-comment period, more than 72,000 comments were filed by interested parties, including medical associations, medical providers, civil-rights

organizations, states, and local governments. *See* 84 Fed. Reg. 23,170, 23,180 & n.41 (May 21, 2019). The comments explained that the proposed Rule's expansive new right-of-refusal provisions were unworkable; that the Rule would upset well-developed practices by healthcare providers and medical schools that respect religious objections without compromising patient care; that it conflicted with federal and state laws and medical ethics; that it would violate patients' and providers' constitutionally protected rights; that it would severely threaten access to reproductive healthcare and LGBT healthcare; and that it threatened to deprive the nation's most vulnerable citizens of healthcare by stripping States and hospitals of Medicare and Medicaid funds.[1]

70. Commenters identified the following problems, among others, with the proposed Rule:

(a) The Rule would conflict with long-standing practices by healthcare providers and medical schools that protect both the interests of healthcare workers and entities with religious objections and the rights of the patients whom they serve. Indeed, commenters explained, the Rule's prohibitions are framed so broadly that they invite healthcare workers to deny information and treatment to people without even alerting the medical facility or the patient that they have done so, thereby preventing the facility or the patient from protecting the patient's interests.[2]

(b) Because the Rule would interfere with the effective management of religious objections, it would increase barriers to care and deprive some patients of care altogether—including in emergency situations. Commenters demonstrated that when healthcare providers give

[1] Medicare is the federal insurance program principally for elderly and disabled individuals. Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is administered by the States, according to federal requirements, and is funded jointly by States and the federal government.

[2] *See, e.g.,* Comments of Lambda Legal HHS-OCR-2018-0002-72186; Comments of Office of the County Counsel, County of Santa Clara HHS-OCR-2018-0002-54930; Comments of GLMA HHS-OCR-2018-0002-71703; Comments of National Family Planning & Reproductive Health Association HHS-OCR-2018-0002-70260.

religious concerns priority over patient well-being, patients are denied care and information about treatment options.[3]

(c) The Rule would encourage discrimination by health professionals based on sex, sexual orientation, gender identity, transgender status, and HIV status.

(d) Because it allows the imposition of catastrophic sanctions while failing to articulate practicable methods of compliance, the Rule would cause many healthcare providers to scale back their services drastically or close certain of their clinics completely, for fear of losing hundreds of millions of dollars of funding for the rest of the medical services that they provide.[4]

(e) The Rule would impose significant administrative burdens on healthcare providers, including burdens resulting from the rule's recordkeeping and other compliance requirements.[5]

(f) The Rule would prevent medical schools from adequately training doctors to meet their professional obligations and would impair the ability to run teaching hospitals and research facilities.[6]

71. The American Medical Association (AMA), among others, urged HHS to withdraw the Denial-of-Care Rule.[7] The AMA stated that the Rule would "undermine patients' access to medical care and information, impose barriers to physicians' and health care institutions' ability to provide treatment, impede advances in biomedical research, and create confusion and uncertainty

[3] *See, e.g.,* Comments of Office of the County Counsel, County of Santa Clara HHS-OCR-2018-0002-54930; Comments of Center for Reproductive Rights HHS-OCR-2018-0002-71830; Comments of Lambda Legal HHS-OCR-2018-0002-72186; Comments of Americans United for Separation of Church and State HHS-OCR-2018-0002-71232; Comments of GLMA HHS-OCR-2018-0002-71703.

[4] Comments of National Family Planning & Reproductive Health Association HHS-OCR-2018-0002-70260; Comments of Wisconsin Hospital Association, Inc. HHS-OCR-2018-0002-66144.

[5] Comments of Wisconsin Hospital Association, Inc. HHS-OCR-2018-0002-66144.

[6] Comments of Association of American Medical Colleges HHS-OCR-2018-0002-67592 ("AAMC Comment").

[7] Comments American Medical Association HHS-OCR-2018-0002-70564, at 1. The AMA is the largest association of doctors and medical students in the United States. The AMA's mission is "to promote the art and science of medicine and the betterment of public health." The AMA maintains the AMA Code of Medical Ethics, a guide to the ethical practice of medicine created by the AMA in 1847.

among physicians, other health care professionals, and health care institutions about their legal and ethical obligations to treat patients." Similarly, the Association of American Medical Colleges warned that adoption of the Rule would "result in harm to patients, undermine standards of medical professionalism, and raise serious concerns regarding individuals' rights that are protected by other federal and state laws."[8]

D. The Final Denial-of-Care Rule

72. Despite the significant concerns raised during the comment period, HHS published the final Rule in the Federal Register on May 21, 2019. *See* Protecting Statutory Conscience Rights in Health Care, 84 Fed. Reg. 23,170 (May 21, 2019). It is attached as Exhibit 1 and incorporated by reference.

73. In adopting the final Rule, HHS failed adequately to address many of the serious issues raised by commenters, including the practical difficulties associated with the Rule, its conflict with obligations relating to emergency care and informed consent, and its detrimental effects on patients. HHS also lacked data to support its decisions and conclusions, refused without justification to credit the data that commenters submitted to it, and failed to consider alternatives to the Rule that would impose fewer costs and burdens on patients and providers. Furthermore, HHS repeatedly declined to clarify key issues or to provide guidance to regulated entities necessary for them to implement the Rule, stating instead that it would consider numerous questions on a case-by-case basis.

74. For example, HHS acknowledged that it "received comments expressing concern about the impact of the rule on access to care in rural communities, underprivileged communities, or other communities that are primarily served by religious healthcare providers or facilities." 84 Fed. Reg. at 23,180. The agency responded by stating that finalizing the rule is appropriate even if the rule "impact[s] overall or individual access to a particular service," such as abortion or treatment

[8] AAMC Comment at 1. The AAMC is not-for-profit association of 151 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. The AAMC serves more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

for gender dysphoria. *Id.* at 23,182. Although it acknowledged that it lacked data to support this assumption, HHS asserted that the rule would be "reasonably likely to increase, not decrease, access to care" in underserved communities by attracting providers who otherwise would not practice medicine because of their religious objections. *Id.* at 23,180. In support, HHS cited a small, outdated, and unreliable political poll, *id.* at 23,181, in which responders stated that they would not practice medicine if doing so involved violation of their religious or moral convictions but said nothing about *where* they would practice medicine. HHS cited no data showing that the Rule was needed to keep providers from quitting or that it would attract any new providers to underserved communities. HHS also failed to address how an increase in providers that refuse to provide care would address the concern that patients will struggle to get the care that they need. Moreover, HHS's evaluation prefers certain types of care over others: The agency assumes that access to care will increase, and cites this as a benefit of the Rule, but does not contradict comments asserting that certain types of care, including reproductive healthcare and LGBT care, will be reduced, especially in rural areas.

75. HHS rejected comments observing that the Rule conflicted with EMTALA. *See* 84 Fed. Reg. at 23,182-23,183. But it failed to address whether emergency exceptions are permissible, and it cited cases where nurses with religious objections were required to assist patients in emergencies as examples of discrimination that it was trying to remedy. *Id.* at 23,176. HHS also stated that driving a patient to the hospital in an ambulance for an emergency procedure may qualify as assisting in the performance of a procedure, *id.* at 23,188, without acknowledging that the procedure (removal of an ectopic pregnancy) could be necessary to save the patient's life. In so doing, HHS failed to provide any clear rule for determining whether or when ambulance drivers and paramedics might object under the Rule to caring for or transporting a patient, instead stating that this determination depends on the facts and circumstances of each case. *Id*. HHS also failed to acknowledge or address the risk to patients' lives if paramedics or other individuals who provide emergency care refuse to administer needed treatments or refuse to transport patients when no alternate staff member is immediately available to perform the service.

76. HHS acknowledged that the Rule has the potential to harm patients. *See* 84 Fed. Reg. at 23,251 ("First, the patient's health might be harmed if an alternative is not readily found, depending on the condition. Second, there may be search costs for finding an alternative. Third, the patient may experience distress associated with not receiving a procedure he or she seeks."). Yet it made no efforts to craft provisions that would reduce the risk of harm to patients. Instead, without evidence, HHS downplayed the risks that patients would be harmed by assuming that various types of objections would not be raised. *See*, *e.g.*, *id.* at 23,188 (stating that HHS is unaware of any medical professionals who would object to treating or transporting patients experiencing complications after an abortion); *id.* at 23,244 (stating that HHS "is unaware of any religious or ethical belief systems that prohibit treatment of a person on the basis of their HIV status"). It also suggested, without citing statutory language, that the enactment of religious-objection laws justified any harm to patients resulting from their enforcement. *See, e.g.,* 84 Fed. Reg. at 23,251 (recognizing that "some patients do experience emotional distress as a consequence of providers' exercise of religious beliefs or moral convictions" but stating that Congress "did not establish balancing tests that weigh such emotional distress against the right to abide by one's conscience").

77. HHS asserted that any harm to patients was attributable not to the Denial-of-Care Rule but to the religious-objection statutes themselves. For that reason, HHS deemed it unnecessary to quantify the harm to patients. It concluded that "it is appropriate to finalize this rule . . . even though the Department and commenters do not have data capable of quantifying all of its effects on the availability of care." 84 Fed. Reg. at 23,182. Again invoking purported congressional policy, the agency deemed religious refusals "worth protecting even if they impact overall or individual access to a particular service, such as abortion." *Id.*; *see id.* at 23,251 (asserting that "objections based on potential (often temporary) lack of access to particular procedures as a result of enforcement of the law are really objections to policy decisions made by the people's representatives in Congress").

1. The Rule's Overly Broad and Distorted Definitions

78. Although HHS repeatedly attributes the Rule's harmful consequences to the underlying statutes, the Rule sharply departs from the will of Congress. The Rule contains

numerous prohibitions, applicable to specified funding recipients, that purport to implement the religious-objection laws. *See* 84 Fed. Reg. at 23,264, § 88.3. But the Rule defines or redefines key statutory terms, expanding their reach far beyond their ordinary meaning and congressional intent. *See* 84 Fed. Reg. at 23,263-23,264, § 88.2.

79. Through these overly broad definitions, the Rule will encourage individuals or institutional healthcare providers, or even someone with only a tangential connection to a procedure (such as a receptionist, lab technician, bookkeeper, janitor, or volunteer), to claim an absolute right to refuse to provide or have any connection whatsoever to providing healthcare and information based on a religious or moral objection—regardless of the impact on patients and on other healthcare providers. The Rule also invites these individuals to refuse to provide a referral to another provider or even general information about services to which the refuser objects, thereby denying patients critical information about their treatment options. Taken together, these definitions will embolden almost any person or entity whose work has even a vague tie to healthcare delivery to decline to provide and even to block needed medical care, services, administrative support, advice, and information.

80. The Rule redefines key terms with extraordinary and unwarranted breadth, distorting the underlying statutes' meaning. These terms are either undefined or more narrowly defined in the underlying statues. When read together, the definitions of "assist in the performance," "refer," "health care entity," and "discriminate" greatly expand the Rule's prohibitions beyond the authority granted in any of the statutes. The Rule therefore interconnects various, separately enacted provisions of the Coates, Weldon, and Church Amendments to create an unlawful regulation that expands religious refusals to an unworkable, dangerous degree. For example, as discussed more fully below, the definition of "assist in the performance" includes the term "refer," which in turn is defined with unprecedented breadth.

81. The Rule prohibits all federal funding recipients, including subrecipients, from "requir[ing]" any "individual to perform or **assist in the performance** of any part of **a health service program or research activity** . . . if the individual's performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or

moral convictions." 84 Fed. Reg. at 23,265, § 88.3(a)(2)(vi) (emphasis added). The Rule defines the key terms with extraordinary and unwarranted breadth, thus distorting the underlying statutes' meaning.

82. First, the Rule defines "**assist in the performance**" extremely broadly to include activities only tangentially related to any healthcare procedure. Only the Church Amendments refer to "assist[ing] in the performance" of an activity, and nothing in that statutory scheme envisions the broad definition in the Rule. 42 U.S.C. § 300a-7. Under the Rule, however, to "assist in the performance" means to "take an action that has a specific, reasonable, and articulable connection to furthering a procedure or a part of a health service program or research activity undertaken by or with another person or entity," including "counseling, referral, training, or otherwise making arrangements for the procedure or a part of a health service program or research activity, depending on whether aid is provided by such actions." 84 Fed. Reg. at 23,263, § 88.2.

83. HHS rejected arguments that the definition was too broad, explaining instead that the agency intends the Rule to be defined expansively. 84 Fed. Reg. at 23,186-23,187. The agency likewise defended its inclusion of counseling and referral within the definition of "assist in the performance," asserting without authority that these are "common and well understood forms of assistance that help people reach desired medical ends." *Id.* at 23,188. But Congress made specific references to "counsel[ing]" in one of the Church Amendments' provisions, "training" in the Coats-Snowe Amendment, and "refer for" in the Weldon Amendment. The separation of these terms in the statutes is evidence of Congress's intent to distinguish them. Yet the Rule includes each category of actions, which themselves are defined with incredible breadth, within the definition of "assist in the performance." The inclusion of a panoply of additional activities within the definition of "assist in the performance" is contrary to the statutes.

84. Second, the Rule defines "**referral or refer**"—terms that are part of the definition of "assist in the performance"—with extreme breadth. Expanding those terms beyond any commonsense understanding or traditional meaning in the medical context, the Rule defines them to include the "provision of information in oral, written, or electronic form (including names, addresses, phone numbers, email or web addresses, directions, instructions, descriptions, or other

information resources), where the purpose or reasonably foreseeable outcome of provision of the information is to assist a person in receiving funding or financing for, training in, obtaining, or performing a particular health care service, program, activity, or procedure." 84 Fed. Reg. at 23,264, § 88.2. This definition goes far afield from what is traditionally considered referral or counseling, instead expanding it to invite an individual worker—one who may lack the medical expertise or information about a patient's medical history to understand the implications of this decision—to refuse to notify either the patient or the worker's employer of the decision to deny information or care. When read in conjunction with the definition of "assist in the performance," this definition empowers an unprecedented universe of individuals to deny care and information without providing these essential and ethically required notifications. The limited provisions of the Rule that permit healthcare providers to require certain, limited advance notice of refusals, discussed more fully below, are not sufficient to cure the unreasonable breadth and unworkability of this definition.

85. By defining participation in a procedure as any activity with "a specific, reasonable, and articulable connection" to a procedure; by explicitly including referrals, counseling, training. and arrangements for a procedure; and by defining "referral" to include the provision of any information that may foreseeably lead a person to obtain training, funding, or services, the Rule vastly expands the class of people who will be empowered to assert objections and the activities that may be the subject of objections.

86. The Rule defines "**workforce**" broadly to mean "employees, volunteers, trainees, contractors, and other persons whose conduct, in the performance of work for an entity or health care entity, is under the direct control of such entity or health care entity, whether or not they are paid by the entity or health care entity, as well as health care providers holding privileges with the entity or health care entity." 84 Fed. Reg. at 23,264, § 88.3. The proposed Rule defined the word "individual"—a word used in several of the Rule's prohibitions—to include any member of an entity's workforce. 83 Fed. Reg. at 3924, § 88.2. That definition of "individual" was deleted from the Rule, but the definition of "workforce" was retained. And the preamble's discussion of that decision makes clear that HHS's Office for Civil Rights still asserts that it may interpret that term

to include members of the "workforce" as defined in the Rule, stating that "sometimes [the term individual] refers to members of the workforce of an entity or health care entity. . . ."). 84 Fed. Reg. at 23,199.

87. The preamble to the Rule makes clear that these definitions allow objections to be raised by a receptionist who schedules an appointment, a janitor who prepares an operating room, an orderly who provides patients with assistance in the recovery room, or an ambulance driver who transports a patient to the hospital. *See* 84 Fed. Reg. at 23,186-23,187.

88. Indeed, the Rule could be read to cover virtually any healthcare-related task, including providing information about treatment options and coverage information to allow for informed consent; providing, collecting, or filing forms related to patients' health history, insurance information, or informed consent; escorting patients to treatment areas; cleaning or restocking treatment rooms, operating rooms, ambulances, or other facilities to allow for treatment of patients; billing, collecting fees for, and administering insurance reimbursements for treatment; and even minor administrative, clerical, or supporting tasks such as scheduling appointments. Invoking the definitions of "assist in the performance" and "refer," a worker could feel empowered to object to providing even basic information to a patient—such as information about insurance coverage, the phone number of a medical office, or directions to a bus stop—on the theory that the worker would thereby be "assisting in the performance" of a procedure to which the worker has a moral objection.

89. These terms reach even further when read in conjunction with the Rule's definition of "**discriminate**." As noted above, several statutes prohibit discrimination based on the assertion of religious objections in specified circumstances. The Rule includes prohibitions employing language from these statutes (*e.g.*, 84 Fed. Reg. at 23,265, § 88.3(a)(2)(iv), citing 42 U.S.C. 300a-7(c)(1)), but defines the word "discriminate" in an unreasonable and arbitrary manner, dramatically expanding what the supposed authorizing statutes actually require or provide. That definition has no basis in law and undermines policies designed to reconcile religious objections and the needs of patients.

90. Under the Rule, "discriminate" means "(1) [t]o withhold, reduce, exclude from, terminate, restrict, or make unavailable or deny any grant, contract, subcontract, cooperative

agreement, loan, license, certification, accreditation, employment, title, or other similar instrument, position, or status; (2) [t]o withhold, reduce, exclude from, terminate, restrict, or make unavailable or deny any benefit or privilege or impose any penalty; or (3) [t]o utilize any criterion, method of administration, or site selection, including the enactment, application, or enforcement of laws, regulations, policies, or procedures directly or through contractual or other arrangements, that subjects individuals or entities protected under this part to any adverse treatment with respect to individuals, entities, or conduct protected under this part on grounds prohibited under an applicable statute encompassed by this part." 84 Fed. Reg. at 23,263, § 88.2.

91. This definition appears to classify as prohibited discrimination any action having the slightest negative effect, even if there is a compelling reason for that action. Although Title VII of the Civil Rights Act of 1964 provides that employers need not provide accommodations for an employee's religious beliefs when the accommodation would cause undue hardship to the employer, the Rule incorporates no such consideration and does not recognize any exception for business necessity or acknowledge that employers may have legitimate, nondiscriminatory reasons for an allegedly adverse employment action. As a result, it appears that a healthcare entity could be deemed to have engaged in unlawful discrimination when it takes measures that are reasonably necessary to ensure patient care notwithstanding the religious views of individual workers—such as taking religious objections into account when making scheduling decisions, enforcing policies requiring advance notice of religious objections, requiring employees to tell someone when they have refused to provide care to a patient, or considering whether a job candidate is willing to perform the essential duties of the position or deliver healthcare services critical to the providers' mission when making hiring decisions.

92. HHS incorporated into the definition of "discrimination" exceptions that purportedly allow certain methods, such as advance-notice requirements and use of alternate staff, that providers use to reconcile objections with the needs of patients. But these provisions are unreasonably narrow, vague, and unworkable.

93. First, the definition states that "an entity subject to any prohibition in this part shall not be regarded as having engaged in discrimination against a protected entity where the entity

offers and the protected entity [*i.e.*, an employee or volunteer] voluntarily accepts an effective accommodation for the exercise of such protected entity's protected conduct, religious beliefs, or moral convictions." 84 Fed. Reg. at 23,263, § 88.2. The requirement that an accommodation be "voluntarily accept[ed]" does not say what providers should do when an employee rejects an offered accommodation and demands an accommodation that would put patients at risk or otherwise compromise patient care.

94. The definition also states that "an entity subject to any prohibition in this part may require a protected entity to inform it of objections to performing, referring for, participating in, or assisting in the performance of specific procedures, programs, research, counseling, or treatments, but only to the extent that there is a reasonable likelihood that the protected entity may be asked in good faith to perform, refer for, participate in, or assist in the performance of, any act or conduct just described. Such inquiry may only occur after the hiring of, contracting with, or awarding of a grant or benefit to a protected entity, and once per calendar year thereafter, unless supported by a persuasive justification." 84 Fed. Reg. at 23,263, § 88.2.

95. This provision sharply constrains providers' ability to require that workers provide notice of their objections to procedures. Healthcare institutions may ask about "specific" procedures, research, and treatment only; they may ask for advance notice of objections only if there is "a reasonable likelihood" that the particular worker will be asked to participate in the particular procedures; they may ask only *after* the worker is hired and then only once per year thereafter. The Rule does not indicate how providers may handle unanticipated objections or situations. Nor does it authorize providers to adopt policies requiring workers to alert them when the workers decline to provide needed medical care or information to a patient, or (if the workers have given such notice) when they decide to object to additional categories of patients or procedures. And the Rule prohibits any questioning about religious objections before hiring, notwithstanding the immense burden that would fall on a healthcare provider if it learned after hiring a worker that the worker is unwilling to perform the critical and even primary aspects of the job for which the worker was hired.

96. Finally, the Rule limits the ability of healthcare providers to ensure that patients are not denied care because of a religious objection. The Rule states that "[t]he taking of steps by an entity subject to prohibitions in this part to use alternate staff or methods to provide or further any objected-to conduct . . . would not, by itself, constitute discrimination or a prohibited referral, if such entity does not require any additional action by, or does not take any adverse action against, the objecting protected entity (including individuals or health care entities), and if such methods do not exclude protected entities from fields of practice on the basis of their protected objections. Entities subject to prohibitions in this part may also inform the public of the availability of alternate staff or methods to provide or further the objected-to conduct, but such entity may not do so in a manner that constitutes adverse or retaliatory action against an objecting entity." 84 Fed. Reg. at 23,263, § 88.2. By appearing to foreclose requiring any "additional action" by objectors, the Rule suggests that providers may not even require objectors to assist in transferring patients to alternative providers or to tell patients that an alternative provider is available. Instead, the Rule envisions that providers will post public notices to inform patients about the availability of alternatives. That will create anxiety by alerting patients that some of a healthcare facility's staff may refuse to treat them. The patients may have no idea that they may need a treatment to which a healthcare worker might object. This inappropriately shifts to patients the burden of anticipating possible objections by employees and finding a way to ensure that they still can receive needed care and information.

97. The Rule also expansively redefines "**health care entity**"—a phrase that is used in both the Coats-Snowe Amendment and the Weldon Amendment and is specifically defined in each. The Rule's new definition expands "health care entity" to include new entities not covered by either statute. In so doing, the Rule goes far beyond those statutes' scope.

98. Under the Coats-Snowe Amendment, "health care entity" "includes an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions." 42 U.S.C. § 238n(c)(2). Under the Rule, "health care entity" for purposes of the Coats-Snowe Amendment includes "an individual physician or other health care professional, including a pharmacist; health care personnel; a participant in a program of training in the health professions; an applicant for training or study in the health professions; a post-graduate

physician training program; a hospital; a medical laboratory; an entity engaging in biomedical or behavioral research; a pharmacy; or any other health care provider or health care facility." 84 Fed. Reg. at 23,264, § 88.2.

99. Under the Weldon Amendment, "'health care entity' includes 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." *E.g.,* Pub. L. 115-245, § 507(d)(2), 132 Stat. 2981, 3118 (2018). But in the Rule, "health care entity" for purposes of the Weldon Amendment is defined to include "an individual physician or other health care professional, including a pharmacist; health care personnel; a participant in a program of training in the health professions; an applicant for training or study in the health professions; a post-graduate physician training program; a hospital; a medical laboratory; an entity engaging in biomedical or behavioral research; a pharmacy; a provider-sponsored organization; a health maintenance organization; a health insurance issuer; a health insurance plan (including group or individual plans); a plan sponsor or third-party administrator; or any other kind of health care organization, facility, or plan." 84 Fed. Reg. at 23,264, § 88.2.

100. Through these sweeping definitions, the Rule broadens the universe of potential objectors to include individuals and entities not included in either of the statutory definitions of "health care entity," including applicants for training and study and pharmacists. And the Rule expands the definition of "health care entity" for purposes of the Coats-Snowe Amendment to include any healthcare professional, healthcare provider, or healthcare facility, notwithstanding that such general terms do not appear in the statutory definition.

101. The Rule uses the term "**sterilization**" to describe medically necessary, gender-affirming healthcare procedures sought by transgender patients. It does so to justify denials of care to transgender and gender-nonconforming patients. But that understanding of the term sterilization is inaccurate—it is contrary to current medical, traditional, and commonsense understandings of the term. The Rule cites *Minton v. Dignity Health*, No. 17-558259 (Calif. Super. Ct. Apr. 19, 2017), as justification for the Rule's enactment. *See* 84 Fed. Reg. at 23,276, n.27. *Minton* concerned whether a Catholic hospital was justified in blocking a surgeon's performance of a hysterectomy

on a transgender patient as part of the patient's prescribed course of treatment for gender dysphoria based on the hospital's religious objection to "sterilization." But equating treatment for gender dysphoria with sterilization is medically inaccurate. Procedures undertaken for the purpose of sterilization are distinct from medical procedures undertaken for other purposes that incidentally affect reproductive function. The Rule also expressly and improperly declines to rule out whether treatment for cancer, such as chemotherapy or surgical removal of testes or ovaries to treat cancerous tumors, could constitute "sterilization" simply because such treatment also could affect reproductive function. The Rule's targeting of transgender patients by adopting a particular religious definition of "sterilization" violates statutory nondiscrimination requirements and medical and ethical standards of care, improperly endorses a particular religious belief, and threatens the provision of medically necessary healthcare to transgender patients, thereby threatening public health.

2. The Rule's Inadequate Explanation of Emergency Exceptions, Compliance Certification, and Notice Requirements

102. The Rule contains no exception for emergencies. In the Rule's preamble, HHS specifically contemplates that individuals will deny patients access to necessary care even in emergency situations in which no alternative provider is available. Further, HHS cites cases involving people being required to provide emergency care as evidence of the need for the Rule. *See, e.g.,* 84 Fed. Reg. at 23,176 (citing *Cenzon-Decarlo v. Mount Sinai Hosp.*, No. 09 CV 3120(RJD), 2010 WL 169485, at *1 (E.D.N.Y. Jan. 15, 2010), *aff'd*, 626 F.3d 695 (2d Cir. 2010) (only on-call nurse did not want to provide emergency care for patient suffering from severe preeclampsia)); *id.* at 23,176 n. 27 (citing *Means v. U.S. Conference of Catholic Bishops*, No. 1:15-CV-353, 2015 WL 3970046 (W.D. Mich. 2015) (hospital turned away patient, refusing to complete miscarriage following premature rupture of membranes, risking grave threats to patient's health)). HHS also cites as evidence of the need for the rule a medical-ethics opinion requiring emergency care notwithstanding religious objections. *See* 83 Fed. Reg. at 3888 (citing, as evidence of the denial of conscience rights in medicine, an American Congress of Obstetricians and Gynecologists ethics opinion advising that providers have an obligation to provide emergency care in certain

circumstances). These examples illustrate HHS's intent to authorize the denial of care to patients even in emergencies and in derogation of patients' constitutionally protected rights. HHS's only response is that it will decide on a case-by-case basis how emergency needs and conscience objections should be reconciled. 84 Fed. Reg. at 23,176.

103. The Rule requires funding recipients to certify their compliance with the Rule and imposes recordkeeping requirements. 84 Fed. Reg. at 23,269-23,271, § 88.4-88.6. But the Rule provides no practical guidance on compliance; it does not specify what form that the records should take or how they should be maintained.

104. The Rule includes a notice requirement that will encourage individuals to unilaterally refuse to provide care and information to patients. 84 Fed. Reg. at 23,270, § 88.5. The notice purports to be "voluntary," but the Rule pressures recipients to post certain recommended text. The Rule states that OCR "will consider an entity's voluntary posting of a notice of nondiscrimination as non-dispositive evidence of compliance" with the Rule, as long as "such notices are provided according to the provisions of this section." *Id.* The Department will take into account where the notice is published—*e.g.*, whether it is "[i]n a prominent and conspicuous physical location" where it can be readily observed by the recipient's workforce and the public; in personnel manuals; and in employment applications. *Id.* § 88.5(b). The Rule recommends that the notice read: "You may have the right under Federal law to decline to perform, assist in the performance of, refer for, undergo, or pay for certain health care-related treatments, research, or services (such as abortion or assisted suicide, among others) that violate your conscience, religious beliefs, or moral convictions." 84 Fed. Reg. at 23,272, App. A to Pt. 88. This recommended notice does not suggest that the objector must comply with advance-notice requirements, that the objector must cooperate in handing off the patient to another workforce member, or that the objector must assist in an emergency. The posting of a notice in the recommended form therefore would undermine policies designed to reconcile religious objections with the needs of patient care. Yet the Rule does not state what the consequences will be for failing to post a notice in this form.

3. The Rule's Vague and Coercive Enforcement Provisions

105. The Denial-of-Care Rule threatens entities that violate the Rule with punitive sanctions, up to and including the total withdrawal and even clawback of Medicare and Medicaid reimbursements and all other federal funds. *See* 84 Fed. Reg. at 23,180 (emphasizing that remedies may include "termination of relevant funding, in whole or in part" and "funding claw backs to the extent permitted by law"); 84 Fed. Reg. at 23,271, § 88.7(i) (remedies for noncompliance with the Rule include withholding, denying, or terminating existing federal funding; denying or withholding new federal funding; and suspending award activities).

106. These penalties could be applied for even a single violation by a covered entity or a violation by a subrecipient or contractor. Direct recipients bear "primary responsibility to ensure that" their subrecipients are "in compliance with Federal conscience and anti-discrimination laws and this part, and shall take steps to eliminate any violations of the Federal conscience and anti-discrimination laws and this part." 84 Fed. Reg. at 23,270, § 88.6(a). The Rule makes clear that if "a sub-recipient is found to have violated the Federal conscience and anti-discrimination laws, the recipient from whom the sub-recipient received funds may be subject to the imposition of funding restrictions or any appropriate remedies available under this part, depending on the facts and circumstances." *Id.* The preamble further states that the conduct of contractors is attributable to States and local governments. 84 Fed. Reg. at 23,207 ("The conduct and activities of contractors engaged by the Department, a Departmental program, or a State or local government is attributable to such Department, program, or government for purposes of enforcement or liability under the Weldon amendment.").

107. Moreover, although the Rule asserts that matters will be resolved informally "whenever possible," it makes clear that loss of all funds can still be immediate: "Attempts to resolve matters informally shall not preclude OCR from simultaneously pursuing any action described in § 88.7." 84 Fed. Reg. at 23,271-23,272, § 88.7(h)(2).

108. The preamble to the proposed Rule asserted that the Department may regulate an unspecified "broader range of funds or broader categories of covered entities" for "noncompliant entities." 83 Fed. Reg. at 3898. In other words, HHS asserted the power to withhold not only federal

funds that are used for programs in which violations are occurring, but also federal funds used for programs unrelated to any alleged offense. And the Rule provides that OCR may temporarily withhold "Federal financial assistance or other Federal funds, in whole or in part, pending correction of the deficiency," without limiting that authority to funds from HHS, a limitation that is present in other provisions of the same section. 84 Fed. Reg. at 23,272, § 88.7(i)(3)(i).

109. These draconian enforcement mechanisms will have the effect of intimidating and coercing healthcare providers—leading them to adopt overly limiting constructions of ambiguous provisions or to stop providing certain services altogether. Likewise, direct recipients that face liability for violations by subrecipients will have little option but to regulate aggressively or to pull funding from subrecipients, particularly those that provide abortion, contraception, or LGBT healthcare, as well as those that will not alter their nondiscrimination or emergency policies.

110. The Rule provides no mechanisms for notice, a hearing, or an appeal before HHS terminates or withholds funds for asserted violations of the Rule.

111. The Rule provides no guidelines as to which enforcement mechanisms HHS will use in particular circumstances, instead leaving it entirely to the discretion of enforcement officials. As a result, HHS officials could employ the most draconian punishments for even the most trivial technical violations, and the healthcare provider would have no outlined avenue for appeal.

112. Moreover, the Rule threatens recipients and subrecipients with onerous compliance and investigation requirements that infringe on patient privacy. *See* 84 Fed. Reg. at 23,270, § 88.6(c) (each recipient and subrecipient "shall cooperate with any compliance review, investigation, interview, or other part of OCR's enforcement process, which may include the production of documents, participation in interviews, response to data requests, and making available of premises for inspection where relevant"). Investigations are mandatory whenever there is a violation or "threatened" or "potential" violation, which can be demonstrated through "any information." *Id.* at 23,271, § 88.7(d) ("OCR shall make a prompt investigation, whenever a compliance review, report, complaint, or any other information found by OCR indicates a threatened, potential, or actual failure to comply with Federal health care conscience and associated anti-discrimination laws or this part.").

113. Each recipient or subrecipient is required to "permit access by OCR during normal business hours to such of its books, records, accounts, and other sources of information, as well as its facilities, as may be pertinent to ascertain compliance with this part." The Rule expressly overrides patients' privacy rights, stating that "[a]sserted considerations of privacy or confidentiality may not operate to bar OCR from evaluating or seeking to enforce compliance with this part. Information of a confidential nature obtained in connection with compliance reviews, investigations, or other enforcement activities shall not be disclosed except as required in formal enforcement proceedings or as otherwise required by law." 84 Fed. Reg. at 23,271, § 88.5(c).

114. Given the expansiveness and vagueness of the Rule, and the severity of its penalty provisions, any individual or entity receiving federal funding—including direct recipients and subrecipients, hospitals, independent providers, contractors, and affiliates—faces a substantial risk of crippling sanctions. To avoid severe penalties, providers must either risk violating the laws (and ethical and professional obligations) that require them to provide timely and adequate access to information and care to patients, or cease offering services to which some employee or volunteer might potentially object, including reproductive-health services, care for LGBT patients, and end-of-life care.

115. The Rule thus creates especially strong disincentives for healthcare entities to provide reproductive-health services and services to LGBT patients, for fear that their funding (including their ability to obtain Medicare and Medicaid reimbursements) will be terminated and their ability to provide medical care to underserved populations will be severely reduced or curtailed.

116. The threat of punitive sanctions under the Rule also will deter healthcare facilities from taking remedial action against discrimination by an employee against patients or other employees, even when that discrimination is *not* tied to any religious belief.

E. The Rule's Immediate and Irreparable Harms

1. Overview

117. The Denial-of-Care Rule will harm local governments, hospitals, small clinics, local providers, community centers, healthcare and professional associations and their members, and

their patients. These harms will occur nationwide. They will directly and irreparably injure Plaintiffs, their members, their employees, and their patients.

118. The Rule privileges particular religious views over all other medical, legal, and operational concerns, and it will force Plaintiff healthcare providers to rewrite their existing policies to the extent that they are inconsistent with the Rule. Providers will have to choose between two unacceptable courses of action: compromising their missions, operations, and medical ethics and placing patients at risk by attempting to comply with the Rule, or jeopardizing the federal funding supporting many of their most important functions and services. And even if providers attempt to comply, the uncertainty created by the Rule will pose staffing, budgeting, and operational dilemmas. The Rule fails to give providers necessary guidance on how the Rule will be applied. As a result, it leaves providers unsure of what is required of them during emergencies, preventing them from making critical judgments about the degree of redundant staffing and other measures that they must implement to minimize the risk of harm to patients that may result from the Rule. The Rule will further harm Plaintiffs' operations by undermining patient trust, constraining already limited resources, and flooding Plaintiffs' facilities with patients denied care by other providers.

119. Patients will suffer the gravest harms. Some patients will be denied care (including lifesaving care) or denied information needed for informed consent. Other patients will be exposed to physical, mental, and dignitary harms, in violation of their constitutional rights. And many of the most vulnerable patients will be afraid to give their providers information that is critical to establishing the clinical relationship and guiding appropriate care—an unconstitutional chilling of speech that harms patients and providers alike. If Plaintiffs are forced out of business or forced to stop offering certain healthcare services, patients will be delayed in obtaining care and may be entirely unable to obtain care.

120. The Rule threatens patients' ability to obtain needed and even emergency care in accordance with their medical needs, and in some instances their own religious and moral beliefs, particularly with respect to contraception, abortion, end-of-life care, and gender-affirming healthcare. It encourages and in some instances may require the imposition of the beliefs of a single employee on healthcare institutions and patients, thereby overriding or preventing patients' access

to healthcare. It also invites discrimination on the basis of sex, gender identity, transgender status, and disabilities such as addiction and positive HIV status. It deprives patients in need of reproductive healthcare and transgender and gender-nonconforming patients of their right to equal dignity and stigmatizes them as second-class citizens. And it impermissibly burdens and chills constitutionally protected speech by threatening to penalize certain individuals based on their gender identity, gender expression, or medical history.

121. The harms imposed on Plaintiffs, their members, and their patients reflect the harms that will be imposed on all similarly situated providers across the country. The Rule will be unworkable for any hospital or facility committed to providing objective, compassionate, and responsible abortion, contraception, or transition-related healthcare, because most, if not all, hospitals rely on HHS for a large percentage of their funding. Smaller medical providers may be forced to close or sacrifice elements of the care that they provide, compromising their core missions. And if Plaintiffs are either forced out of business or forced to stop offering certain healthcare services, patients will likewise be delayed in accessing care and in some instances will be entirely unable to access care.

122. Hospitals, clinics, community health centers, and other facilities that are unprepared to risk the loss of federal funding may entirely forgo providing abortion, contraception, or LGBT services (including referrals to such services). Indeed, the Rule will chill the provision of care in any medical facility that is unwilling or unable to take on the risks imposed by the Rule.

123. At facilities that do continue to provide services to which some staff members may object, the delivery of that care will suffer. Patients will be more likely to experience discriminatory treatment or be denied care altogether because a member of the workforce disapproves of them or the treatment they seek.

2. Harms to the County of Santa Clara

124. The County, through its departments and agencies, is committed to delivering high-quality care, including to underserved and vulnerable populations, in settings that protect and respect patients, their families, and providers alike. County departments already have in place nondiscrimination and conscience-objection policies that respect and comply with existing legal

requirements and medical ethics. If the Denial-of-Care Rule goes into effect, the County will immediately need to rewrite and re-evaluate all of its conscience-objection polices, and it will need to inquire as to the conscience objections of thousands of employees newly covered under the Rule.

125. For example, Valley Medical Center has a policy allowing its current and prospective medical staff and employees to request in writing not to participate in certain patient care that conflicts with staff members' cultural values, ethics, or religious beliefs. Once an exemption is requested, the appropriate manager or director determines whether the request can be granted in light of staffing levels and other relevant circumstances. If the request is granted, the staff member's tasks, activities, and duties may be redistributed to ensure appropriate patient care. The policy makes clear that requests for exemptions will not result in disciplinary or recriminatory action. A manager or director may decline to accept an employee or medical-staff member for permanent assignment, however, if the staff member has requested not to participate in an aspect of care that is commonly performed in that assignment. The policy makes clear that patient care must not be adversely affected by the granting of an exemption and that medical emergencies take precedence over personal beliefs.

126. Valley Medical Center designed this policy to appropriately address the healthcare needs of patients, including patients' rights to be treated in a nondiscriminatory manner, and Valley Medical Center's need to plan in advance to ensure appropriate staffing, as well as to respect the cultural values and ethical and religious beliefs of employees. Without prior notice and the ability to plan assignments around conscience objections, the County would be unable to staff many of its operations appropriately. Further, it is critical to patient care and to hospital functionality that Valley Medical Center be able to rely on all medical staff to assist a patient in the event of an emergency.

127. O'Connor and St. Louise Hospitals have similar policies regarding religious and moral objections to providing certain patient care, with comparable requirements for advance notice and attending to emergencies. In the near future, those facilities will transition to the Valley Medical Center policy, as part of their ongoing integration into the County's health system.

128. The County is extremely concerned about the lack of an emergency exception on the face of the Rule. An objector's refusal to assist in patient care during an emergency could lead to delays in care and worse medical outcomes, including fatalities. If it cannot rely on all staff to provide care in an emergency, the County will have to consider whether backup or double staffing is necessary to protect patient welfare. Moreover, the Rule's lack of clarity about whether and when an emergency exception exists creates unacceptable operational uncertainty, leaving the County in the dark about what policies it would need to put in place around emergencies to be able to certify compliance with the Rule.

129. Further, under a regime that permits only occasional inquiry into employees' objections and only voluntarily accepted accommodations, the County will be unable to ensure proper patient care. For example, at some County-run pharmacies, there is only one pharmacist on site at any given time. Patients will be prevented from obtaining their prescribed medications if a pharmacist unilaterally decides not to provide certain types of medication, or not to serve certain people, without first discussing the issue with a manager and agreeing to some accommodation.

130. The requirement that accommodation be "voluntarily accept[ed]," 84 Fed. Reg. at 23,263, § 88.2—meaning that staff must consent to any reassignment or shifting of hours made to account for religious objections—will similarly pose staffing challenges for the County's many critical health-related programs. The County must ensure that there are sufficient non-objecting staff members to cover each shift and ensure continuous patient care. If an employee's religious objection is incompatible with that person's role, the person may need to be reassigned to another role. And for some positions, no accommodation will be possible. For example, if a receptionist objected to informing people that County hospitals provide contraceptive and abortion care and also objected to connecting patients with someone who could discuss those options, there would be no accommodation the County could offer that would avoid compromising access to care.

131. The Rule allows for an employer to ask for notice of an employee's religious or moral objections once a year. But it does not address what should happen if an employee develops an objection after having already told the employer that he or she has no objections. The County must be able to obtain or require notice of all religious or moral objections; otherwise, it could face

a situation where a staff member unexpectedly objects to care, leading to staffing issues and lack of continuous patient care. Under the Rule, the County could be wholly unaware that an objector had ceased performing his or her assigned duties on the basis of a religious or moral objection, which would gravely compromise patient care and the functioning of the County's health systems. The Rule's failure to address these concrete logistical issues poses significant operational challenges to the County and unacceptable health risks to patients.

132. The Rule will have grave effects on the County's Gender Health Center. The Clinic's mission is to provide the care necessary for people of all ages to understand and explore their gender identity. The Rule will imperil that mission because it will require the County to allow employees who object on religious or moral grounds to the Clinic's mission to work in that setting.

133. The Rule's notice provision will adversely affect the County. The Rule's model notice tells employees that they "have the right to decline to participate in, refer for, undergo, or pay for certain health care-related treatments, research, or services . . . which violate your conscience, religious beliefs, or moral convictions under Federal law." That might encourage or suggest that it is permissible for employees to, for example, refuse to treat a transgender patient who comes to the emergency room seeking care for a broken arm, based on the provider's "moral convictions," even though refusal of service would violate federal nondiscrimination law and EMTALA, 42 U.S.C. § 1395dd. And if the patient sees the notice, the patient would be discouraged from communicating openly with the provider, for fear that services will be denied. Under the Rule, the County must choose between displaying the model notice, or something like it, and risking loss of federal funding for its decision not to display the model notice.

134. In the County's view, complying with the Denial-of-Care Rule is operationally unworkable, endangers patient health, and creates insurmountable staffing challenges. Further, the Rule will require the County to risk malpractice actions or other suits by patients whose healthcare was negatively affected by a County employee's refusal to provide care. Were the County to fail to provide care in an emergency situation because of an employee's religious or moral objection, the County might run afoul of state and federal laws requiring hospital emergency departments to provide evaluation and emergency aid and requiring its Behavioral Health Services Department to

provide timely access to an adequate network of mental-health care. *See* EMTALA, 42 U.S.C. § 1395dd; Cal. Health & Safety Code §§ 1317-1317.10 (2008); 42 C.F.R. §§ 438.206-438.208.

135. The County faces withdrawal or even clawback of hundreds of millions of dollars in federal funding annually if the Rule is enforced against it. 84 Fed. Reg. at 23,271, § 88.7(i). Without federal funding, the County's ability to provide a broad range of quality health services to many thousands of patients—including to infants and children, those with chronic diseases, the indigent, and the elderly—would be greatly diminished or potentially eliminated. These vulnerable patients would face increased healthcare costs and would likely have little choice but to forgo care or to seek it in already crowded emergency rooms of other hospitals. And those patients may face additional barriers to treatment at those hospitals if those hospitals are covered by the Rule.

136. Because Valley Medical Center and other County healthcare facilities are safety-net providers that primarily serve low-income individuals, vulnerable communities will be severely harmed by a loss of federal funding. For example, the Public Health Department's direct services primarily benefit low-income persons, children, people of color, and people living with chronic diseases such as HIV/AIDS. Because all 15 cities within the County are dependent on the County's public health department, many, if not most, of these individuals simply would not get the care and resources that they need without federally funded services from the Public Health Department.

137. Further, the Rule creates untenable budgetary uncertainty for the County as a whole, because the County is unsure what the Rule requires and whether the County is able to comply with the Rule. This makes it infeasible for the County entirely to mitigate the risk that noncompliance with the Rule could cause the County to lose more than a billion dollars in necessary federal funding.

2. Harms to Private Healthcare Providers

138. Plaintiffs include clinics and healthcare providers that operate independently from other healthcare systems, each with missions that include providing comprehensive and compassionate care. For example, Trust Women Seattle's mission is to treat patients with dignity, empathy, and respect, to give them complete and accurate medical information and to empower them to make decisions free from judgment or disruptions in their care. Likewise, the mission of

the LA LGBT Center—the Nation's largest provider of LGBT medical and mental-health services—is to provide a safe and affirming environment for LGBT people seeking healthcare services. To fulfill that mission, the LA LGBT Center must be able to treat its patients with dignity, empathy, and respect; to give them complete and accurate medical information; and to empower them to make decisions free from judgment or disruptions in their care. At Hartford Gyn, clinic procedures and practices are designed to ensure that patients receive the highest quality, nonjudgmental care. Hartford Gyn and Trust Women have taken a public stance defending reproductive rights. Abortion clinics and their patients are routinely targeted and harassed, including by protestors outside clinics and by groups and individuals who pose grave security threats to physicians, staff, and volunteers. Hartford Gyn and Trust Women have been targeted by the anti-choice movement for harassment and threatened violence, and they are symbols of the determined provision of constitutionally protected care. Ensuring the safety of everyone in the clinic, including patients, is of paramount concern for both providers.

139. Whitman-Walker, Bradbury-Sullivan Center, Center on Halsted, and the Mazzoni Center also are mission-driven healthcare providers and entities.

140. In the reproductive-healthcare and LGBT-healthcare settings, the Rule invites individuals to deny patients care and information, which will threaten both the health of patients and the sustainability of the providers' operations. The Rule will frustrate these mission-driven providers' ability to hire personnel who will work to support their missions. By expanding the definition of what it means to "assist in the performance" of a procedure to include people not directly engaged in providing care, and by inviting religious or moral objections without notice to patients or providers, the Rule threatens grave harms to the healthcare-provider Plaintiffs' operations, provision of care to their patients, their core missions, and their reputations.

141. The Plaintiff healthcare providers seek to empower patients to make their own decisions. But the Rule's broad definitions invite an employee to substitute his or her own opinion about a patient's care for sound medical judgment and the patient's consent. As with Santa Clara, these providers could face situations in which a staff member unexpectedly objects to care, leading to staffing issues and inadequate responses in an emergency. Even worse, Plaintiffs could be wholly

unaware that an objector has ceased performing his or her assigned duties on the basis of a religious or moral objection, or has turned a patient away altogether, which would gravely compromise patient care and Plaintiffs' missions. The Rule's failure to address these concrete logistical issues poses unacceptable operational challenges and health risks to patients.

142. Small providers face a significant concern that staff members who assert unanticipated objections will be able to unilaterally veto key aspects of patient care. This concern affects even clinics devoted to providing reproductive or LGBT care. For example, someone willing to process billing for pregnancy services may have objections to contraception or abortion, or someone comfortable with scheduling an appointment for gay patients may have objections to transgender patients. Because the Rule is designed to protect objectors from any consequences, providers may be forced to reorganize their staffing structures, consume precious resources with unnecessary workarounds, duplicate staffing in cost-prohibitive ways, unfairly burden nonobjecting employees, reduce services, and even close programs in an attempt to reduce the risk that a single employee will deny care or information to a patient.

143. Trust Women Seattle, for example, is a small business. It cross-trains clinical and some nonclinical staff to serve multiple roles, many of which touch on providing information about or scheduling, or directly providing abortion, contraception, or transgender healthcare. Likewise, Hartford Gyn must operate efficiently because of its already limited income. In order to do so, all staff must perform functions that touch on providing abortion and contraception. No alternative human-resources structure could sustain the clinic.

144. At Trust Women Seattle, some employees monitor the provision of abortion care and contraceptive care at the clinic. Others perform medication management, sanitize instruments, and clean operating rooms and laboratories that may be used for general gynecological exams one day and the provision of contraception or hormone therapy the next. Under the Rule, these sanitary and custodial activities could fall within the definition of "assist in the performance," though they do not involve the direct provision of care.

145. Further, Trust Women has an emergency policy requiring all office personnel to be familiar with the facilities' agreements to transfer patients to other facilities in the case of an

emergency. This policy requires that any staff member assist in an emergency transfer, even if only by calling ahead to the hospital. Hartford Gyn likewise has emergency practices requiring all staff to be willing to help in an emergency. Trust Women also has a "no turn-away" policy for patients and a nondiscrimination policy. To the extent that the Rule would prevent Trust Women and Hartford Gyn from continuing to enforce these policies, it would be unworkable. To the extent that they would be prevented from requiring that front-facing employees like receptionists (who do not assist in procedures according to Trust Women's current understanding) are compassionate and supportive of the independent decision-making of patients, it would both undermine Trust Women's business and inhibit its patients' access to healthcare.

146. The Rule will strain already limited resources. Because patients will fear refusal of care at traditional healthcare facilities, providers such as the LA LGBT Center and Whitman-Walker that specialize in reproductive and LGBT healthcare likely will see an increase in demand resulting from patients' hope that those clinics, which are designed to meet their specific needs, will remain safe spaces. The same is true for plaintiffs who provide abortion and contraception care. Such an increase will strain the limited resources of these providers. At the same time, the providers will need to invest resources in educating the community about the Rule and in battling the erosion of community members' confidence in the healthcare system that will result from the Rule's application. These consequences will increase the LA LGBT Center's and Whitman-Walker's operating costs and will take a toll on the health and well-being of the LGBT community.

147. In anticipation of the release of the Rule, Center on Halsted's staff already has been forced to devote resources to addressing the Rule. It has conducted additional "Know Your Rights" programming regarding discrimination against LGBT people; sent and prepared staff to attend meetings and events with other LGBT stakeholders in the city; and held internal training for staff to manage the added strains on the mental health of Center on Halsted's patients. This diversion and additional expenditure of resources frustrates Center on Halsted's efforts to counsel those whom it serves and to advocate for them to receive necessary healthcare services from outside organizations.

148. As a result of the Rule, Bradbury-Sullivan Center will be required to redirect its staff and resources from providing its own services to assisting patrons in determining who among the healthcare providers in the region will serve LGBT patients in a nondiscriminatory manner. Indeed, Bradbury-Sullivan Center already has had to divert staff and resources from other program activities to advocacy, policy analysis, and development of additional resources to address the ill effects of the Rule.

149. Loss of funding threatens dire results for these Plaintiffs. For example, Trust Women Seattle and Hartford Gyn are dependent on Medicaid funding to continue providing the full range of services they offer patients and keep their doors open.

3. Harms to Patients

150. If implemented, the Rule will harm Plaintiffs' patients. The Rule attacks access to reproductive and LGBT healthcare at hospitals, clinics, and other facilities throughout the country and invites an unprecedented number of individuals to delay or deny care to patients, directly affecting the patients' access to healthcare. As detailed in the comments to the proposed Rule, discrimination against these patients already is widespread and well-known, as are the harms that result from delayed and denied care.

a. Harms to patients generally

151. Healthcare refusals often result in significant costs for and harms to patients. Under the Rule, an individual employee, because of that employee's morally or religiously motivated refusal to provide care, may force a patient to choose between forgoing care or taking on the burden of locating and traveling to a willing provider. When patients are turned away from a doctor's office or a hospital without a referral or even basic information about their condition or treatment options, they must find willing providers to provide the healthcare that they need. They incur additional expenditures of time and money researching and trying other providers, including additional time off work for new appointments. In areas with a limited number of affordable healthcare providers, patients may need to travel long distances to find care, requiring additional travel expenses, sometimes including overnight stays and childcare. The harms from the additional time and expense

fall most heavily on low-income individuals and those without the job flexibility to take paid sick time. Some patients will lack the resources to continue to pursue the treatment they need.

152. Patients seeking treatment from healthcare entities of last resort, such as the County and other Plaintiffs, may be entirely denied the care that they seek and desperately need.

153. The Rule may result in denials of time-sensitive or emergency care, putting patients' health and even their very lives at substantial risk.

154. Because the Rule does not always require objecting providers to alert either their employers or the patients about religious or moral objections (and permits healthcare employers to require such notice only in limited circumstances), the Rule may mean not only that some patients will be denied necessary care, but also that those patients will not know that they are being denied that care on the basis of an employee's religious objection. That will be true even if the patient chooses to go to a particular healthcare facility because the facility normally provides that care. Either way, the patient is harmed. If patients know that they are being denied care because of who they are or what services they seek, that is a stigmatizing and potentially traumatizing experience. If patients do not know that they are being denied the care that they seek, they will not know to seek it elsewhere and their healthcare needs will remain unmet.

b. Special burdens on reproductive rights

155. The Rule threatens to impede or eliminate access to abortion and contraception.

156. Patients who are denied contraception are less able to safeguard their own health and welfare.

157. The ability to prevent or space pregnancy, facilitated by easy and affordable access to contraception, has significant health benefits.

158. Abortion is a fundamental part of healthcare. It is a common medical procedure: one in three women in the United States has undergone an abortion and an estimated one in four women will need an abortion in the future. And it is extremely safe: it is 14 times safer than childbirth and even safer than a shot of penicillin. But abortion care already is a marginalized healthcare service, often provided at clinics that operate independently from other healthcare systems. Because of increasing regulation and targeting of abortion clinics and their staff for violence and harassment,

there is a national shortage of abortion providers in the United States, and their numbers are shrinking. As a result, a woman who is denied abortion care at a healthcare facility may find it difficult to find an available provider in a reasonable timeframe. Eighty-nine percent of counties in the United States do not have a single abortion clinic, and some counties that have a clinic provide abortion services only on certain days. Several States have only one clinic that provides abortion care anywhere within the State.

159. Reproductive choice is a reality for patients only when there are enough family planning providers available to meet patients' needs and those providers are available in an equitable distribution. Currently, the supply of those providers is not meeting the needs of U.S. patients, in large part because facilities providing abortion are increasingly concentrated in cities, and very few primary-care providers are skilled in family-planning services.

160. Four of the ten largest healthcare systems in the United States by hospital count are now religiously sponsored, often because of hospital consolidations between Catholic or other religious healthcare systems and secular institutions. As a result of hospital mergers and other factors, significant parts of the Southern and Midwestern United States have deserts of abortion training and care.

161. Hospitals across the United States are large businesses that demand significant administrative resources. Many hospitals already decline to provide contraception and abortion because of the effort required to accommodate refusals and the additional expense that they entail. If the Rule goes into effect, the United States will see an even more dramatic reduction in the number of large medical education institutions that provide abortions and teach students and residents about it. Access to these services in the United States already is very limited, and the Rule will immeasurably exacerbate the problem.

162. Because of the shortage of providers, patients already must travel long distances (and incur the associated costs) to obtain abortion care. In addition, in some areas the shortage of providers results in significantly increased wait times or leads to some patients' being turned away altogether.

163. Delays in obtaining an abortion compound the logistical and financial burdens that patients face and substantially increase the health risks to patients. On average, patients must wait at least a week between initially attempting to make an appointment and receiving an abortion. Delays also increase the cost of an abortion, because abortions during the second trimester are substantially more expensive than during the first trimester: The median price of a surgical abortion at ten weeks is $508; the cost at 20 weeks rises to $1,195. Other costs also increase with delays. For example, one recent study found that Utah's mandatory waiting period caused 47 percent of women having an abortion to miss an extra day of work. More than 60 percent of the women in the study were negatively affected in other ways, including having to pay increased transportation costs, lost wages, or having to disclose the abortion to someone whom they otherwise would not have told. Delays in obtaining an abortion also mean that patients obtain that care in later stages of pregnancy. Although abortion is a safe procedure, risks increase with later gestational ages. Patients approaching legal limits in their State for obtaining a medical abortion may be forced to seek care in another State. Because the Rule will create incentives for more healthcare providers to stop offering abortion services, it will increase delays and add to the costs of obtaining an abortion.

164. The Rule also further stigmatizes abortion and contraception. Stigma has tremendous impact on patients, fostering fear and psychological stress. When patients perceive the community's disapproval of their choice, they feel the need to maintain secrecy around their decisions and will be deterred from seeking care out of fear of judgment and discrimination.

165. Patients seeking treatment from healthcare entities of last resort, such as the County and other Plaintiffs, may be entirely denied the care that they seek and desperately need, even in emergency situations. This will put patients' health and even their lives at substantial risk. If patients are denied care entirely, they will encounter a whole host of additional harms. Denying someone an abortion and forcing them to carry to term increases the risk of serious health harms, including eclampsia and death. In addition, denying someone an abortion may lead to increased risk of life-threatening bleeding, cardiovascular complications, diabetes associated with pregnancy, as well as all other risks of pregnancy. A pregnant person is 14 times more likely to die from giving birth than from having an abortion.

166. Whether because patients encounter an objector, providers are forced to close their doors, or patients are deterred from seeking care because of stigma and fear of discrimination, individuals seeking abortion and contraception will be either delayed or totally denied such care because of the Rule.

167. Objections to other types of procedures will also increase healthcare costs. For example, a patient who has a cesarean section and wants to have a postpartum tubal ligation immediately following delivery might be denied that option by an employee of a healthcare facility who objects to the latter procedure—even though having the procedure at that time is medically recommended, presents fewer risks to the patient, and is more cost-effective than delaying the procedure. If the patient cannot have that procedure immediately following delivery, the patient must first recover from the cesarean surgery and then schedule the tubal ligation at least six weeks later, when the patient is busy caring for a newborn; the patient will be required to go to another doctor and possibly a different hospital; will have to arrange for the transfer of medical records; and will incur duplicative costs and duplicative risks, pain, and recovery time for the second round of anesthesia and invasive surgery.

c. Special burdens on LGBT patients

168. The Rule imposes particular burdens on transgender and gender-nonconforming people as well. Transgender people are defined as transgender because their gender identity does not align with the sex that they were assigned at birth. Gender identity refers to an individual's sense of being a particular gender, and constitutes an essential element of human identity. Everyone possesses a gender identity, which is innate, has biological underpinnings, and is fixed at an early age. An individual's sex is generally assigned at birth solely on the basis of visual observation of external genitalia. Other sex-related characteristics such as chromosomes, hormone levels, internal reproductive organs, secondary sex characteristics, and gender identity typically are not assessed or considered during the assignment of sex at birth. Most people have a gender identity that matches their sex assigned at birth and other sexual characteristics.

169. Where an individual's gender identity does not match that individual's sex assigned at birth, gender identity is the critical determinant of sex. External genitalia are but one of several

sex-related characteristics and are not always indicative of a person's sex. A scientific consensus recognizes that attempts to change an individual's gender to bring it into alignment with the sex assigned at birth are ineffective and harmful.

170. The dissonance between individuals' gender identity and the sex that they were assigned at birth can be associated with clinically significant distress, which is known as gender dysphoria. Gender dysphoria is a medical condition recognized in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and by leading medical and mental-health professional groups, including the AMA and the American Psychological Association (APA).

171. Gender dysphoria can be treated in accordance with internationally recognized Standards of Care formulated by the World Professional Association for Transgender Health and recognized as authoritative by national medical and behavioral health organizations such as the AMA and APA.

172. The ability to live in a manner consistent with one's gender identity is critical to a person's health and well-being and is a key aspect in the treatment of gender dysphoria. The process by which transgender people come to live in a manner consistent with their gender identity, rather than the sex they were assigned at birth, is known as transition. The steps that each transgender person takes to transition are not identical, but usually include social, legal, and medical transition. Medical transition includes treatments that bring transgender people's bodies into alignment with their gender identity, such as hormone-replacement therapy or surgical care such as hysterectomy or orchiectomy. Whether any particular treatment is medically necessary or even appropriate depends on the medical needs of the individual.

173. All Plaintiffs, regardless of whether they provide particular transition-related treatments and services, are committed to providing inclusive and individually tailored gender-affirming care and services that respect each patient's gender identity and status without discrimination, in accordance with medical and ethical standards of care.

174. LGBT individuals, and especially transgender and gender-nonconforming people, already face particularly acute barriers to care and health disparities that will be compounded by

the Rule. A majority of LGBT patients fear going to a healthcare provider because of past experiences of anti-LGBT bias in a healthcare setting. Many LGBT patients report negative experiences, including hostility, discrimination, and denials of care, when they disclose to healthcare providers their sexual orientation, history of sexual conduct, gender identity, transgender status, or history of gender-affirming medical treatment, and related medical histories.

175. For example, multiple LGBT patients at Whitman-Walker have previously been refused medical care, including routine care unrelated to gender dysphoria, by providers outside of Whitman-Walker simply because they are transgender or gay. In one instance, a radiological technician refused to perform an ultrasound for testicular cancer on a transgender patient. In another, a healthcare worker at a dialysis clinic confronted a Whitman-Walker patient with end-stage renal disease and objected to being involved in the patient's care because of hostility to his sexual orientation. In another, after a Whitman-Walker patient—a transgender teenager—was hospitalized in a local hospital following a suicide attempt, the staff would only address or refer to the young person with pronouns inconsistent with their gender identity, exacerbating the teenager's acutely fragile state of mind. Local hospitals and surgeons have refused to perform transition-related surgeries on Whitman-Walker transgender patients, even when they routinely perform the very same procedures on non-transgender patients, including in situations when the patient's insurance would have covered the procedure or when the patient was able to pay for the procedure. Many local primary-care physicians unaffiliated with Whitman-Walker have refused to prescribe hormone therapy for transgender patients. And multiple Whitman-Walker patients have been denied prescriptions by pharmacists. Behavioral-health providers at Whitman-Walker report that the vast majority of transgender patients—as many as four out of five—report instances of mistreatment or discrimination by healthcare providers, hospitals, clinics, doctors' offices, or other facilities outside of Whitman-Walker.

176. Patients of the LA LGBT Center report similar experiences of discrimination by other providers. One transgender patient, who developed profuse bleeding after surgery, was denied treatment at an emergency room and arrived at the LA LGBT Center in distress three days later, having lost a significant amount of blood. Another patient required extensive surgery to repair

damage caused by a prior silicone breast-augmentation procedure. But she was turned down by an academic plastic-surgery center in Los Angeles because her surgeon there said that her health problems were caused by her own poor decision-making and she therefore would not be considered for treatment. By the time she was able to identify a surgeon who was willing to treat her, with the assistance of a physician at the LA LGBT Center, years had passed and her condition had become life-threatening. For patients at the LA LGBT Center, the ability to receive gender-affirming medical care can mean the difference between life and death.

177. In many geographic regions, a majority of LGBT people lack a provider whom they consider to be their personal doctor. As a result, when they seek healthcare services, they are likely to encounter a healthcare provider with whom they do not have a relationship. This makes them especially vulnerable to discriminatory treatment from providers who are not LGBT-affirming. For some medical specialties, there are only a handful of healthcare providers in the region who have the expertise necessary to treat a patient for a particular condition, so a denial of care from even one provider could make it practically impossible for an LGBT patient to receive any care at all.

178. In a recent study, nearly one in five LGBT people, including 31 percent of transgender people, said that if they were turned away from a hospital, it would be very difficult or impossible to get the healthcare that they need elsewhere. The rate was substantially higher for LGBT people living in non-metropolitan areas, with 41 percent reporting that it would be very difficult or impossible to find an alternative provider. Even when they are able to get access to care, many individuals report that healthcare professionals have used harsh language toward them, refused to touch them, used excessive precaution, or blamed the individuals for their health status.

179. Consequently, LGBT patients are disproportionately likely to delay preventative screenings and necessary medical treatment and therefore to end up with more acute health problems and outcomes. Research has identified pervasive health disparities for LGBT people with respect to cancer, HIV, obesity, mental health, tobacco use, and more. In other words, LGBT people, who are disproportionately likely to need a wide range of routine medical care, already have reason to fear, and often do fear, negative consequences of "coming out" to healthcare

providers about their sexual orientation, history of sexual conduct, gender identity, transgender status, history of gender-affirming medical treatment, and related medical histories.

180. The Rule encourages these patients to remain closeted to the extent possible when seeking medical care. But remaining closeted to a health care provider may result in significant adverse health consequences. For instance, a patient who conceals or fails to disclose a same-sex sexual history may not be screened for HIV or other relevant infections or cancers, or may not be prescribed preventative medications such as Pre-Exposure Prophylaxis or PrEP, which is extremely effective at preventing HIV transmission. Patients who fail fully to disclose their gender identity and sex assigned at birth may not undergo medically indicated tests or screenings (such as tests for cervical or breast cancer for some transgender men, or testicular or prostate cancer for some transgender women). The barriers to care are particularly high for transgender individuals. Nearly one-quarter of transgender individuals report delaying or avoiding medical care when sick or injured, at least partially because of fear of discrimination by and disrespect from healthcare providers.

181. In the past, OCR has investigated numerous complaints from transgender patients about being denied certain health services, ranging from routine to life-saving care, because of the patients' gender identities. The Rule will make it more likely that these patients will be denied care or will avoid seeking care altogether.

d. Harms to vulnerable populations

182. The effects of refusals will fall particularly heavily on rural patients in need of reproductive healthcare. These patients are four times more likely than urban dwellers to reside in medically underserved communities. Reproductive-health services are especially difficult for rural patients to obtain because obstetric and gynecologic services and other medical specialties are not common in rural settings. Further, for healthcare providers such as the County of Santa Clara that operate clinics and hospitals in rural communities, experience has shown that reproductive health care and gender-affirming health care are frequently in demand, contrary to the Department's assertion that patients in rural communities may be more likely to share providers' religious objections and therefore are not likely to seek such care. *See* 84 Fed. Reg. 23,181. The inappropriate

expansion of refusals under the Denial-of-Care Rule will undoubtedly exacerbate the harms to these individuals.

183. Patients and recipients of non-medical services coming to Trust Women Seattle, Hartford GYN Center, Whitman-Walker, the LA LGBT Center, Bradbury-Sullivan Center, Center on Halsted, and the Mazzoni Center have been disrespected and demeaned by other healthcare providers for their reproductive and LGBT healthcare decisions and will have no other options if they cannot obtain care from these providers. These Plaintiffs serve communities with already limited options for healthcare services.

184. For example, in the region where Bradbury-Sullivan Center is located, there often is only one or very few healthcare providers who have the specialty necessary to treat an LGBT patient for a specific service, so a denial of care from that provider could make it practically impossible for a patient to receive any care at all. And some of the region's healthcare providers are religiously affiliated organizations that could claim religious objections to providing care to LGBT people, exempting them under the Rule from adhering to existing nondiscrimination laws and standards.

185. The Rule will chill the expressive rights of Plaintiffs' patients by causing them to hide their identities and same-sex relationships when seeking healthcare services from other organizations with religious objections to serving LGBT people.

186. Further, the additional demand for services and advocacy caused by discrimination resulting from the Rule will drain the resources of these Plaintiffs.

4. Harms to Medical-Association Plaintiffs

a. AGLP

187. The Denial-of-Care Rule will harm AGLP, its members, and the patients whom they treat because the Rule threatens AGLP's federal funding. AGLP's members depend on that funding to provide vital services and to conduct critical medical research. In addition, the Rule will frustrate AGLP's mission of achieving and enforcing safe workspaces for LGBT psychiatrists and nondiscriminatory healthcare services for AGLP members' patients. The Rule also will frustrate AGLP's mission of advocating for nondiscriminatory standards of care for patients, culturally

competent standards of care for treatment of LGBTQ patients, and nondiscriminatory work environments for members that protect against discrimination on the basis of sexual orientation and gender identity.

188. The Rule invites additional burdens, harassment, and even discriminatory treatment of AGLP members in the workplace by fellow employees who will claim that that the Rule gives them a right to accommodations for discriminatory behavior. AGLP members and their LGBTQ patients are stigmatized and demeaned by the message communicated by the Rule—that their government privileges beliefs that disparage transgender people and their medical needs, and invites denials of care at the cost of the dignity and physical and mental health of patients based solely on transgender status.

b. MSFC

189. The Rule will also cause severe harms to MSFC and its members.

190. First, medical students receive their clinical training disproportionally at academic medical centers and teaching hospitals that receive significant federal funding. Likewise, residents depend on federal funding for their continuing medical education. If HHS determines that the institutions at which these individuals work are violating the Rule, their funding to continue working at that institution may be reduced or eliminated. Those institutions also may stop providing certain services or training in order to avoid risk of catastrophic sanctions under the Rule.

191. Second, MSFC is committed to creating the next generation of abortion providers. There is already a shortage in training opportunities. For example, members of MSFC have reported instances in which facilities across the nation have ceased providing these services based on the religious or moral objection of select staff or funders or because of the stigma and controversy surrounding these services. Even in progressive States, religious refusals by hospital leadership have already pushed abortion training out of certain facilities. Further, mergers of secular teaching hospitals with religiously affiliated facilities have reduced the number of facilities that provide abortion training, and clinic closures across the country further threaten access to training and services.

192. The Rule is so broad as to be unworkable for some hospitals and other facilities providing abortion and contraception, creating incentives for institutions to stop providing and training for abortion services. As a consequence, MSFC members will be able to acquire training at a shrinking number of facilities. As training programs grow more limited, fewer new physicians will be able to achieve competency in family planning sufficient to join existing practices or clinics right out of medical school or residency. The result will be a shrinking pool of providers that will be unable to replenish itself through normal training programs, significantly longer wait times even for patients who are able to travel and can afford to obtain care from trained providers, and decreased access to care for patients around the country.

c. GLMA

193. If not enjoined, the Denial-of-Care Rule will harm both GLMA members and the LGBT patients whose interests GLMA represents. The Rule creates a safe haven for discrimination and prevents GLMA from achieving its goals with professional accreditation bodies by preventing such bodies from holding healthcare providers accountable for discrimination against LGBT people and denial of care whenever the discriminatory conduct is ostensibly grounded in religious beliefs.

194. GLMA collaborates with professional accreditation bodies, such as The Joint Commission, on the development, implementation, and enforcement of sexual-orientation and gender-identity nondiscrimination policies as well as cultural-competency standards of care for treatment of LGBT patients. GLMA has worked with The Joint Commission, and continues to work with similar professional bodies and health-professional associations, on standards, guidelines, and policies that address LGBT health and protect individual patient health and public health in general.

195. In order for a healthcare organization to participate in and receive federal payment from Medicare or Medicaid programs, the organization must meet certain requirements, including a certification of compliance with health and safety requirements. That certification is achieved based on a survey conducted either by a state agency on behalf of the federal government, or by a federally recognized national accrediting organization. Accreditation surveys include requirements that healthcare organizations not discriminate on the basis of sex, sexual orientation, or gender identity in providing services or in employment. A healthcare organization that discriminates in

those ways or that otherwise deviates from medical, professional, and ethical standards of care can lose its accreditation.

196. As explained above, all of the leading health-professional associations, including the AMA, have adopted policies stating that healthcare providers should not discriminate in providing care for patients and clients because of sexual orientation or gender identity.

197. The Rule presents a direct conflict with nondiscrimination standards adopted by the Joint Commission and all the major health-professional associations, which have recognized the need to ensure that LGBT patients are treated with respect and without bias or discrimination in hospitals, clinics, and other healthcare settings.

198. The Rule would prevent state agencies and other recipients of federal funds from recognizing, to the extent allowed by law, the loss of accreditation of a healthcare organization because of specified anti-LGBT beliefs and denials of care. The Rule therefore will frustrate GLMA's mission of achieving and enforcing accreditation standards relating to nondiscrimination on the basis of sexual orientation and gender identity and cultural competency standards of care for treatment of LGBT patients.

199. Some members of GLMA are employed by religiously affiliated healthcare organizations (such as hospitals, hospices, or ambulatory-care centers) that receive federal funding. These healthcare providers treat LGBT patients. Members of GLMA employed by religiously affiliated providers will experience additional burdens for adhering to their medical and ethical obligations to treat all patients in a nondiscriminatory manner, including providing all medically necessary care that is in the patient's best interests.

200. The Rule invites harassment and discriminatory treatment of GLMA members in the workforce by fellow employees who will claim that the Rule gives them a right to accommodation for discriminatory behavior. GLMA members and their LGBT patients are stigmatized and demeaned by the Rule's message that their government privileges beliefs that result in the disapproval and disparagement of LGBT people in the healthcare context.

201. As an organization of health professionals who often serve and care for patients from the LGBT community, GLMA knows that discrimination against LGBT individuals in

healthcare access and coverage remains a pervasive problem and that too often this discrimination is based on religious objections. GLMA members have reported numerous instances of discrimination in care based on religious grounds. Since HHS issued the proposed Rule, GLMA members shared with GLMA many ways that religious objections have been used to the detriment of the healthcare of LGBT patients.

CAUSES OF ACTION

FIRST COUNT
Administrative Procedure Act, 5 U.S.C. § 706(2)(A)
Arbitrary And Capricious

202. Plaintiffs incorporate the preceding paragraphs as if fully set forth here.

203. Defendants are subject to the Administrative Procedure Act (APA), 5 U.S.C. § 551 *et seq. See* 5 U.S.C. § 703.

204. The Denial-of-Care Rule violates the APA, 5 U.S.C. § 706(2)(A), because it is arbitrary, capricious, an abuse of discretion, and not in accordance with law, in that HHS failed adequately to consider important aspects of the issue, including harm to patients, costs to healthcare facilities, impracticability of the Rule for the efficient administration of healthcare facilities and programs and for delivery of health services, and possible alternatives to the Rule.

205. Commenters showed that the Denial-of-Care Rule will cause substantial harms to patients. The Rule nonetheless fails adequately to quantify and inappropriately disregards these costs and harms, particularly in its cost-benefit analysis. HHS also has ignored that the Rule is unnecessary and that current law provides sufficient protection for religious objectors while also considering patients' rights to care and information. Notwithstanding the concerns raised by commenters that the Rule would harm patients, HHS omitted from the Rule any provisions to lessen the Rule's adverse effects on the delivery of healthcare and on patients' health and well-being, instead opting to expand objection rights without regard to the practical effects of the rule on the healthcare system. Further, by failing to address the many issues arising from its requirements, or stating that they will be resolved on a case-by-case basis, the Rule leaves employers in the dark about what they may or may not do without running afoul of the Rule's prohibitions.

206. In addition, HHS adopted an unprecedented, confusing, and unreasonable definition of what it means to "discriminate" against an individual or entity based on a religious or moral objection. HHS's definition would consider virtually any action to manage objections to be "discriminatory" unless the action falls within narrowly drawn and unworkable exceptions. These provisions contain no undue-hardship exception or legitimate-nondiscriminatory-reason defense, and they unreasonably limit the measures providers can take to accommodate religious and moral objections without compromising patient care.

207. Although Commenters detailed the substantial and potentially unmanageable costs of compliance with the Rule and other administrative burdens on healthcare facilities and providers that the Rule would impose, the Rule fails to take account of these costs and burdens.

208. In adopting the final Rule, HHS failed to consider pertinent data and failed to articulate a reasoned or legally sufficient basis for the Rule.

209. In adopting the Rule, HHS failed to consider alternative ways of achieving the objectives of the underlying statutes.

210. Additionally, HHS failed to respond adequately to significant comments critical of the proposed Rule that were submitted during the notice-and-comment period.

SECOND COUNT
Administrative Procedure Act, 5 U.S.C. § 706(2)(C)
Exceeds Statutory Authority

211. Plaintiffs incorporate the preceding paragraphs as if fully set forth here.

212. The Denial-of-Care Rule violates the APA, 5 U.S.C. § 706(2)(C), because it is greatly in excess of statutory jurisdiction, authority, or limitation.

213. When read together, HHS's definitions of critical statutory terms—including "assist in the performance," "referral or refer," "health care entity," and "discrimination"—are inconsistent with the statutory provisions that HHS purports to be construing, as well as the plain, accepted meanings of those terms. As a result, HHS's construction of the statutory provisions that it purports to be implementing is inconsistent with the plain scope and meaning of those provisions, rendering the Rule in excess of statutory jurisdiction and authority.

THIRD COUNT
Administrative Procedure Act, 5 U.S.C. § 706(2)(A)
Not in Accordance with Other Federal Laws

214. Plaintiffs incorporate the preceding paragraphs as if fully set forth here.

215. The Denial-of-Care Rule violates the APA, 5 U.S.C. § 706(2), because it is arbitrary, capricious, an abuse of discretion, and not in accordance with law in that it conflicts with numerous federal laws. These laws include:

(a) 42 U.S.C. § 18114 (because the Rule will impede individuals' timely access to medical care and information about treatment options);

(b) EMTALA, 42 U.S.C. § 1395dd(b)(1) and its implementing regulations (because the Rule will provide blanket license to emergency-room personnel to decline to provide or assist in the provision of emergency services, to decline to facilitate patients' transfer to other facilities, or to decline to make referrals);

(c) ACA, 42 U.S.C. § 18023(d) (because the Rule contravenes the ACA's prohibition against construing right-of-conscience exemptions to relieve any healthcare provider of the legal obligation to provide emergency services as required by State or Federal law, including the EMTALA);

(d) ACA, 42 U.S.C. § 18116 (because the Rule contravenes the statutory provisions stating that "[a]n individual shall not, on [a] ground prohibited under title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or section 504 of the Rehabilitation Act of 1973, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance");

(e) Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e *et seq.* (because in creating such expansive religious-accommodation requirements and inviting employees to veto the types of accommodations that may be offered, the Rule may require employing healthcare entities to take actions that are contrary to the rights of other employees to be free from the forms of discrimination prohibited by Title VII); and

(f) Title X of the Public Health Service Act, 42 U.S.C. §§ 300-300a-6 (because the Rule contravenes Congress' requirement that Title X grantees operate "voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services," 42 U.S.C. § 300(a), and because Title X appropriations bills, *e.g.*, 2019 Continuing Appropriations Act, Pub. L. No. 115-245, Div. B., Tit. II, 132 Stat. 2981, 3070-71 (2018), require that "all pregnancy counseling shall be nondirective," meaning that funded projects are to offer pregnant women neutral, non-judgmental information and counseling regarding their options, including "prenatal care and delivery; infant care, foster care, or adoption; and pregnancy termination").

FOURTH COUNT
U.S. Constitution, First Amendment; Administrative Procedure Act, 5 U.S.C. § 706(2)(B)
Establishment Clause

216. Plaintiffs incorporate the preceding paragraphs as if fully set forth here.

217. The Denial-of-Care Rule is contrary to constitutional rights, powers, privileges, or immunities and therefore must be set aside under 5 U.S.C. § 706(2)(B).

218. The Establishment Clause of the First Amendment prohibits the government from favoring one religion over another or favoring religion over nonreligion.

219. The Establishment Clause permits government to afford religious accommodations or exemptions from generally applicable laws only if, among other requirements, the accommodation (1) lifts a substantial, government-imposed burden on the exercise of religion and (2) does not impose on innocent third parties the costs or burdens of accommodating another's religious exercise.

220. The Rule fails both of these requirements and therefore violates the Establishment Clause.

221. The Rule violates the Establishment Clause because it creates expansive religious exemptions for healthcare employees at the expense of third parties, namely, Plaintiffs, other providers, and, crucially, patients.

222. HHS's asserted statutory authority for the Rule cannot be read to authorize the Rule, because if so read, those statutes would exceed Congress's legislative authority and constitute unconstitutional religious preferences, both by granting religious exemptions for purported burdens on religious exercise that are not of the federal government's own making, and by imposing costs and burdens on third parties to accommodate the religious beliefs or exercise of objecting employees.[9]

223. The effect of the Rule will be that patients who seek care at odds with the religious beliefs of a provider's employee—or whose very identity is at odds with that employee's religious beliefs—may be delayed in receiving care (including emergency care) or denied care altogether. Patients will suffer the stigma of government-sanctioned discrimination. The Rule also will burden Plaintiffs and other providers because by leaving them unable to treat patients in accord with their own ethical and legal obligations and precluding them from carrying out their organizational missions, based solely on the religious views of a single employee.

224. The Rule impermissibly advances religious beliefs in violation of the Establishment Clause because it imposes on Plaintiffs an unqualified obligation to give preferential protection to religious objections of their employees, regardless of the costs and harms to Plaintiffs, their patients, and the greater public health.

225. The Denial-of-Care Rule further violates the Establishment Clause of the First Amendment because, among other reasons, it:

(a) has the primary purpose of favoring, preferring, and endorsing certain religious beliefs and certain religious denominations over others and over nonreligion;

(b) has the primary effect of favoring, preferring, and endorsing certain religious beliefs and certain religious denominations over others and over nonreligion;

[9] Attempts by HHS to mandate federal exemptions from burdens on religious exercise imposed by state or local governments are permissible, only if (among other requirements) there is a clear constitutional commitment of congressional power and express legislative authorization for the federal action. Otherwise, HHS impermissibly intrudes on the States' traditional prerogatives and general authority to regulate for the health and welfare of their citizens, exceeding the federal government's statutory authority in violation of the APA. *See* Second Count, *supra*.

(c) has the primary purpose and primary effect of preferring the religious beliefs of some people and institutions over the lives, health, and other rights and interests of third parties;

(d) impermissibly entangles government with religion;

(e) makes Plaintiffs, their patients, and other third parties bear the costs and harms of objecting employees' religious beliefs or religious exercise; and

(f) imposes on Plaintiffs a requirement to accommodate employees' religious objections without taking constitutionally required account of the actual burdens (if any) on the objectors or the effects on or harms to Plaintiffs, their patients, or the greater public health.

FIFTH COUNT
(Brought by Plaintiffs other than County of Santa Clara)
U.S. Constitution, Fifth Amendment; Administrative Procedure Act, 5 U.S.C. § 706(2)(B)
Substantive Due Process/Right To Privacy And Personal Autonomy

226. Plaintiffs incorporate the preceding paragraphs as if fully set forth here.

227. The Denial-of-Care Rule is contrary to constitutional rights, powers, privileges, or immunities and therefore must be set aside under 5 U.S.C. § 706(2)(B).

228. The Fifth Amendment's Due Process Clause protects individuals' substantive rights to be free to make certain decisions central to privacy, bodily autonomy, integrity, self-definition, intimacy, and personhood without unjustified governmental intrusion. Those decisions include the right to abortion and other reproductive decision-making, as well as the right to live openly and express oneself consistent with one's gender identity.

229. By imposing conditions on funding that require healthcare providers to interfere with and unduly burden patients' access to medically necessary health care, including reproductive healthcare and healthcare necessary to preserve health or life, the Rule violates the rights of Plaintiffs' patients to privacy, liberty, dignity and autonomy guaranteed by the Fifth Amendment.

230. In particular, a person's gender identity and ability to live and express oneself consistent with one's gender identity without unwarranted governmental interference constitutes a core aspect of each person's autonomy, dignity, self-definition and personhood. By imposing conditions on funding that interfere with patients' access to gender-affirming medical care, including surgical procedures, hormone therapy, and other medically necessary care, and by

interfering with the ability of transgender and gender-nonconforming patients to live and express themselves in accordance with their gender identities, the Rule infringes on patients' interests in privacy, liberty, dignity, and autonomy protected by the Fifth Amendment.

231. There is no legitimate interest supporting the Rule's infringement on patients' fundamental rights, let alone an interest that can survive the elevated scrutiny required to justify infringement of these fundamental rights.

SIXTH COUNT
(Brought by Plaintiffs Other Than County of Santa Clara)
U.S. Constitution, First Amendment; Administrative Procedure Act, 5 U.S.C. § 706(2)(B)
Free Speech

232. Plaintiffs incorporate the preceding paragraphs as if fully set forth here.

233. The Denial-of-Care Rule is contrary to constitutional rights, powers, privileges, or immunities and therefore must be set aside under 5 U.S.C. § 706(2)(B).

234. A person's disclosure of transgender or gender-nonconforming status, speech, or expression that discloses gender identity, and the person's gendered speech and expressive conduct, all receive constitutional protection under the First Amendment.

235. The Rule has the purpose and effect of chilling constitutionally protected First Amendment activity. As a result of the Rule, an increased number of LGBT people will remain closeted in healthcare settings and to doctors, nurses, and other healthcare providers, and will decline to disclose their sexual orientation, transgender or gender-nonconforming status, or gender identities. Further, an increased number of LGBT people will decline to engage in gendered speech and expression, including by declining to disclose related medical histories—even when that self-censorship impedes the ability of their healthcare providers to provide appropriate treatment and results in negative health consequences to the patients and to public health.

236. The Rule imposes conditions on funding that invite denials of care to Plaintiffs' patients based on religious or moral objections to these patients' identity or past or present healthcare decisions and needs.

237. The Rule impermissibly chills patients who are seeking medical care from being open about their reproductive-health histories and needs, including abortion and contraception.

238. The Rule will chill a patient of ordinary firmness from making such disclosures.

239. The Rule violates the Free Speech Clause of the First Amendment because it impermissibly burdens the exercise of patients' constitutionally protected speech, expression and expressive conduct based on the content and viewpoint of patients' speech.

240. Additionally, the Rule is overbroad because it will chill protected First Amendment activity.

SEVENTH COUNT
(Brought by Plaintiffs Other Than County of Santa Clara)
U.S.. Constitution, Fifth Amendment; Administrative Procedure Act, 5 U.S.C. § 706(2)(B)
Equal Protection

241. Plaintiffs incorporate the preceding paragraphs as if fully set forth here.

242. The Denial-of-Care Rule is contrary to constitutional rights, powers, privileges, or immunities and therefore must be set aside under 5 U.S.C. § 706(2)(B).

243. The Fifth Amendment's Due Process Clause provides that no person shall be deprived of life, liberty, or property without due process of law.

244. That Clause includes within it a prohibition against the denial of equal protection of the laws by the federal government, its agencies, or its officials or employees.

245. The purpose and effect of the Rule are to discriminate against Plaintiffs' patients based on their sex, gender identity, transgender status, gender nonconformity, and exercise of fundamental rights, including the rights to bodily integrity and autonomous medical decision-making, the rights of access to abortion and contraceptives, and the rights to live and express oneself consistent with one's gender identity.

246. Additionally, the purpose of the Rule is to facilitate, authorize, and encourage private discrimination against Plaintiffs' patients on the basis of sex, gender identity, transgender status, gender nonconformity, and exercise of fundamental rights, including the rights to abortion and contraceptives and to live and express oneself consistent with one's gender identity.

247. Further, the Rule is intended to have, and will have, a disproportionate impact on women and transgender people, people who exercise their rights to abortion and contraception, and

people who wish to live and express themselves consistent with their gender identity. The Rule places an impermissible special burden on these individuals.

248. Discrimination based on sex is presumptively unconstitutional and subject to heightened scrutiny.

249. Discrimination based on gender identity or transgender status also is presumptively unconstitutional and subject to heightened scrutiny. Transgender people have suffered a long history of discrimination and continue to suffer that discrimination; they are a discrete and insular group and lack the power to protect their rights through the political process; a person's gender identity or transgender status bears no relation to that person's ability to contribute to society; gender identity is a core, defining trait that is so fundamental to a person's sense of self and personhood that a person cannot be required to abandon it as a condition of equal treatment; and efforts to change a person's gender identity through intervention have been widely condemned.

250. Discrimination based on the exercise of a fundamental right is presumptively unconstitutional and is subject to strict scrutiny.

251. The Denial-of-Care Rule lacks even a rational or legitimate justification, let alone the important or compelling one that is constitutionally required. The Rule also lacks adequate tailoring under any standard of review.

252. Defendants' requirement of disparate treatment of patients and encouragement of private discrimination deprives patients of their right to equal dignity and stigmatizes them as second-class citizens in violation of equal protection.

EIGHTH COUNT
(Brought only by County of Santa Clara)
Spending Clause

253. Plaintiffs incorporate the preceding paragraphs as if fully set forth here.

254. The Denial-of-Care Rule violates the Spending Clause for at least four reasons.

(a) First, the Denial-of-Care Rule is vague and ambiguous, and it fails to provide adequate notice of what conduct by a recipient would result in HSS withholding federal funds.

(b) Second, the Rule attaches new, after-the-fact conditions to Santa Clara's receipt of federal funds, in violation of the Spending Clause.

(c) Third, the Rule is not rationally related to the federal interest in the particular programs that receive federal funds. *See South Dakota v. Dole*, 483 U.S. 203 (1987); *Massachusetts v. United States*, 435 U.S. 444, 461 (1978) (plurality op.) (conditioning federal grants illegitimate if conditions are unrelated "to the federal interest in particular national projects or programs"). The Rule places various federal grants at risk, but there is no rational relationship between the federal religious-objection laws that Defendants seek to enforce and the federal interest in those programs.

(d) Fourth, the Rule unconstitutionally attempts to coerce state and local government recipients, such as the County of Santa Clara, to adopt the federal government's policy by threatening to withhold, terminate, and claw back unprecedented levels of federal funding, whether or not those funds are related to the provision of health care or to the specific violation alleged. Such conditions on federal funding go beyond "relatively mild encouragement" to put a "gun to the head" of public entities, coercing them to adopt federal policy in contravention of the Spending Clause. *See National Federation of Independent Business v. Sebelius*, 567 U.S. 519, 581 (2012).

NINTH COUNT
(Brought only by County of Santa Clara)
Separation of Powers

255. The Constitution vests the Spending Power in Congress, not in the Executive Branch. U.S. Const. art. I, § 8, cl. 1.

256. Congress may delegate some discretion to the Executive Branch to decide how to spend appropriated funds, but that discretion is cabined by the scope of the delegation. *City of Arlington, Texas v. FCC*, 569 U.S. 290, 297 (2013).

257. The Executive Branch cannot amend or cancel appropriations that Congress has duly enacted. *Clinton v. City of New York*, 524 U.S. 417, 439 (1998); *Train v. City of New York*, 420 U.S. 35, 38, 44 (1975).

258. The Rule imposes requirements not authorized by the underlying federal statutes and would allow defendants to withhold, deny, suspend, or terminate federal financial assistance for noncompliance with those requirements.

259. The Rule's conditions improperly usurp Congress's spending power and amount to an unconstitutional refusal to spend money appropriated by Congress, in violation of constitutional separation-of-powers principles.

260. Defendants' violation causes ongoing harm to the County of Santa Clara and its residents.

TENTH COUNT
Equitable Relief To Preserve Remedy

261. Plaintiffs incorporate by reference the foregoing paragraphs as if fully set forth.

262. The Denial-of-Care Rule will become effective on July 22, 2019, unless it is enjoined. Plaintiffs are entitled to a full, fair, and meaningful process to adjudicate the lawfulness of the Rule before being required to implement its far-reaching and harmful requirements.

263. Plaintiffs will suffer irreparable injury by implementation of the Rule, which would erode hard-won trust between vulnerable populations and their healthcare providers, stigmatize and traumatize patients, interfere with core governmental and medical operations, and result in delays and denials of care leading to physical harm and even death. Preliminary and permanent injunctive relief is therefore needed to ensure that Plaintiffs' injuries are fully remedied.

264. Injunctive relief is also needed to prevent the immediate harm resulting from the uncertainty created by the Rule about the policies and procedures guiding critical medical operations and the conditions being placed on huge swaths of federal funding. On the first day that this Rule takes effect, Plaintiff providers must know how to handle medical emergencies as they happen; they cannot wait to see how HHS chooses to interpret concededly confusing provisions in after-the-fact enforcement actions. The hospitals and clinics that Plaintiffs operate need to know how to staff their facilities, how staff must handle objections when they arise, and whether the providers can rely on continued receipt of federal funding that supports life-saving services. Patients need assurance that they will receive complete, accurate information and timely and responsive medical care in an environment that protects their constitutional rights and does not expose them to stigma and harm. This Court should step in to protect Plaintiffs' institutions, their

patients, and the foremost principle guiding medical providers in responding to those in need of assistance and care—first, do no harm.

265. Accordingly, to ensure that Plaintiffs receive meaningful relief should they prevail in this action, the Court should preliminarily and permanently enjoin Defendants from implementing the Denial-of-Care Rule.

REQUEST FOR RELIEF

Plaintiffs request that the Court grant the following relief:

(a) A declaratory judgment under 28 U.S.C. § 2201(a) and 5 U.S.C. § 706(a) that the Denial-of-Care Rule is unlawful and unconstitutional;

(b) Preliminary and permanent injunctions enjoining Defendants from implementing and enforcing the Denial-of-Care Rule;

(c) Attorneys' fees, costs, and expenses and other disbursements for this action; and

(d) Any further and additional relief that this Court deems just and proper.

Dated: May 28, 2019

Respectfully submitted,

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