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10 IN THE UNITED STATES DISTRICT COURT
 11 FOR THE NORTHERN DISTRICT OF CALIFORNIA

12
 13
 14
 15 **STATE OF CALIFORNIA, BY AND THROUGH
 ATTORNEY GENERAL XAVIER BECERRA,**

16 Plaintiff,

17 v.

18
 19 **ALEX M. AZAR, IN HIS OFFICIAL CAPACITY
 AS SECRETARY OF THE U.S. DEPARTMENT OF
 20 HEALTH & HUMAN SERVICES; U.S.
 DEPARTMENT OF HEALTH AND
 21 HUMAN SERVICES; DOES 1-100,**

22 Defendants.

CASE NO. 4:19-cv-02769-HSG

**CALIFORNIA’S NOTICE OF MOTION
 AND MOTION FOR PRELIMINARY
 INJUNCTION, WITH MEMORANDUM
 OF POINTS AND AUTHORITIES**

Date: October 10, 2019
 Time: 2:00 P.M.
 Dept: 2, 4th Floor
 Judge: The Honorable Haywood S.
 Gilliam, Jr.
 Trial Date: Not set
 Action Filed: May 21, 2019

1 **TO THE DEFENDANTS, AND THEIR COUNSELS OF RECORD:**

2 **PLEASE TAKE NOTICE** that on October 10, 2019 at 2:00 p.m., in Courtroom 2 of the
3 above-entitled court, located at 1301 Clay Street, Oakland, California, Plaintiff the State of
4 California will and hereby does move this Court, under Local Rule 7-2, for a preliminary
5 injunction staying implementation of the final rule, “Protecting Statutory Conscience Rights in
6 Health Care; Delegations of Authority,” 84 Fed. Reg. 23170 (May 21, 2019) (to be codified at 45
7 C.F.R. pt. 88).¹

8 Because the Rule violates the Administrative Procedure Act (APA), as well as the Spending
9 Clause and the Establishment Clause of the First Amendment to the U.S. Constitution, and will
10 cause irreparable harm, the State seeks a preliminary injunction enjoining enforcement and
11 implementation of the Final Rule or an order of postponement of the effective date of the Final
12 Rule pursuant to 5 U.S.C. § 706(2) pending judicial review against Defendants Alex M. Azar, in
13 his official capacity as Secretary of the U.S. Department of Health and Human Services, and the
14 U.S. Department of Health and Human Services (HHS) (collectively, Defendants).

15 This motion is based on this notice, the Memorandum of Points and Authorities, the
16 Declarations of Dr. David H. Aizuss (California Medical Association); Mari Cantwell
17 (Department of Health Care Services); Pete Cervinka (California Department of Social Services);
18 Mark Ghaly (California Health and Human Services Agency); Dr. Jeanne Harris-Caldwell
19 (Health Services Association, California Community Colleges), Bruce Hinze (California
20 Department of Insurance); Kevin Kish (Department of Fair Employment and Housing);
21 Commissioner Ricardo Lara (California Department of Insurance); Dr. Joseph Morris (Board of
22 Registered Nursing); Brandon Nunes (California Department of Public Health); Neli N. Palma
23 (Attorney General’s Office); Frances Parmelee (California Community Colleges); Denise Pines
24 (Medical Board of California) Stirling Price (California Department of State Hospitals); Jay
25 Sturges (California Labor and Workforce Development Agency); Diane Toche (Health Care
26 Services, California Department of Corrections and Rehabilitation); and Christopher M. Zahn

27
28 ¹ Available at <https://www.govinfo.gov/content/pkg/FR-2019-05-21/pdf/2019-09667.pdf>.

1 (American College of Obstetricians and Gynecologists), this Court's file, and any matters
2 properly before the Court.

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MEMORANDUM OF POINTS AND AUTHORITIES**INTRODUCTION**

1 Under the guise of an “anti-discrimination” framework, Defendants’ new Rule, “Protecting
2 Statutory Conscience Rights in Health Care; Delegations of Authority,” seeks to strip patients of
3 their access to vital, life-saving healthcare services in order to promote a nebulous, untethered
4 “right” to object to such services. The Rule allows any healthcare provider, entity, or individual
5 to deny critical healthcare to patients—and does not require that any justification, notice, or
6 alternative referral be given to the patient or employer to offset such denial. Under the Rule, any
7 individual who is loosely affiliated with the provision of care is emboldened to deny healthcare to
8 a patient, even in the case of an emergency. For instance, the Rule could prevent a female who
9 had been sexually assaulted from obtaining information and emergency contraception for
10 pregnancy prevention. And the Rule is not limited to women’s reproductive healthcare, including
11 abortion and contraception; it affects virtually all medical services, including healthcare services
12 for lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) individuals and
13 children. Far from preventing discrimination, this Rule only opens the door to widespread,
14 unfettered discrimination against Californians, including those populations that have historically
15 faced obstacles to obtaining care, for which the state has prioritized more accessible, better care
16 and for which the state has prioritized providing more accessible, better care.

17 The Rule also unfairly targets the State of California and its existing laws, regulations, and
18 policies that already balance conscience protections with patient rights. It threatens to terminate
19 billions of dollars in federal funding that support state public healthcare and other programs
20 unless California capitulates to the Rule’s unlawful provisions. The Rule frustrates California’s
21 public health interests and goals of full and equal healthcare by, among other things, curtailing
22 Californians’ access to reproductive care, and other public health programs, chilling Californians’
23 ability to access care, including in rural communities, further exacerbating long-term health
24 problems. The Rule also requires the State to immediately establish a costly and onerous
25 bureaucratic structure to ensure compliance with the Rule’s vastly expanded provisions, including
26 compliance by any downstream sub-recipients, inclusive of counties and cities.
27
28

1 confirmed that discrimination is “outside the scope” of federal conscience laws: “[G]iven the
2 strong national policies embodied in federal civil rights laws that protect individuals from
3 unlawful discrimination based on their federally protected individual characteristics, and that
4 ensure that federally supported programs are available to all without discrimination, we believe
5 that federal civil rights protections prevail.” *Id.* at 78080.

6 The 2008 rule went into effect on January 20, 2009, except that its certification requirement
7 never took effect, as it was subject to the information collection approval process under the
8 Paperwork Reduction Act, which was never completed. 76 Fed. Reg. 9968, 9971 (Feb. 23, 2011).

9 **B. 2010-2018 Executive Actions**

10 On March 10, 2009, three months after the 2008 rule took effect, HHS proposed to rescind
11 that rule, and moved to stay litigation challenging the 2008 rule, noting that a new round of
12 rulemaking was underway. 74 Fed. Reg. 10207 (Mar. 10, 2009).⁵ Instead, in 2011, HHS
13 amended the 2008 rule by removing provisions containing definitions of terms, requirements,
14 prohibitions, and the certification requirement. *See generally* 73 Fed. Reg. 78072, 76 Fed. Reg.
15 9968. The 2011 rule also noted that federal conscience laws “were never intended to allow
16 providers to refuse to provide medical care to an individual because the individual engaged in
17 behavior the health care provider found objectionable.” 76 Fed. Reg. 9973-74. HHS confirmed
18 that “[n]o statutory provision, however, requires promulgation of a rule.” *Id.*; 76 Fed. Reg. at
19 9975 (the Church, Weldon, and Coats-Snowe Amendments do not require “promulgation of
20 regulations for their interpretation.”). The 2011 rule designated the Office for Civil Rights (OCR)
21 of HHS to “receive complaints based on the Federal health care provider conscience protection
22 statutes,” and to “coordinate the handling of complaints with funding components from which the
23 entity, to which a complaint has been filed, receives funding.” 76 Fed. Reg. at 9975, 9977.

24 **C. 2018 and 2019 Executive Action**

25 Between 2008 and January 26, 2018—approximately ten years—OCR states that it had
26 received a total of 44 complaints. 83 Fed. Reg. 3880, 3886 (Jan. 26, 2018). In spite of the limited

27 _____
28 ⁵ *State of Connecticut v. U.S.*, No. 3:09-cv-00054-RNC (D. Conn. Jan. 15, 2009), Dkt. 93; Kim
Worobec, *HHS’ New Provider Conscience Regulations*, 21 Health Law 35 at 37 (April 2009).

1 number of complaints received, on January 26, 2018, Defendants issued a Notice of Proposed
2 Rulemaking (NPRM) to vastly expand implementation and enforcement of over two dozen
3 federal conscience laws. *Id.*

4 The NPRM proposed a broad exemption to opt out of healthcare services on the basis of
5 “conscience, religious beliefs, or moral convictions” not only to medical providers but also to
6 anyone with an “articulable connection” to the provision of that service, including helping to
7 make a referral for that service. 83 Fed. Reg. at 3881, 3923. Specific scenarios included
8 abortion, sterilization, euthanasia, certain vaccinations if there is a connection to use of “aborted
9 fetal tissue,” contraception, gender transition/gender dysphoria, tubal ligations, hysterectomies,
10 assisted suicide, and referrals for advanced directives, and “other health services.” 83 Fed. Reg.
11 at 3903. HHS also proposed to grant responsibility for enforcement of two dozen federal
12 conscience laws to OCR by conferring OCR with the authority to not only receive complaints, but
13 also to initiate compliance reviews, conduct investigations, supervise and coordinate compliance,
14 and use broad enforcement tools to address violations, including temporarily withholding
15 payments; denying use of HHS funds; suspending award activities; terminating HHS funds; and
16 withholding new HHS funds. 83 Fed. Reg. at 3931.

17 HHS received over 242,000 comments to the NPRM.⁶ Comments in opposition came from
18 a broad array of individuals, major medical associations, public health experts, state and local
19 governments, healthcare providers, and other patient advocacy organizations.

20 On May 21, 2019, HHS issued the final rule (Rule). Despite the over 242,000 comments,
21 the Rule is largely identical to the NPRM. Like the proposed rule, the final rule conflicts with
22 existing law and impedes the provision of and access to medical information and healthcare by
23 attempting to create limitless categories under which medical information and care can be
24 refused. The final Rule so conflicts by misconstruing and exceeding the bounds of federal
25 statutes, including well-established statutory language and definitions. For example, the Rule

26 _____
27 ⁶Comments are available at
28 <https://www.regulations.gov/docketBrowser?rpp=50&so=DESC&sb=postedDate&po=0&dct=PS&D=HHS-OCR-2018-0002>. Although the website shows 72,417 comments, the Rule lists 242,000 comments as of the date the Rule was published. 84 Fed. Reg. at 23180, n. 41.

1 broadly and unclearly defines “assist in the performance” of an activity to encompass an action
2 that has a “specific, reasonable, and articulable connection” to furthering a procedure, health
3 service program, or research activity, including “counseling, referral, training, or otherwise
4 making arrangements” for the procedure, health program, or research activity. 84 Fed. Reg. at
5 23263. Only the Church Amendments refer to (but do not define) “assist in the performance” of
6 an activity, and nothing in that statutory scheme envisions the broad definition in the Rule. 42
7 U.S.C. § 300a-7. In fact, Congress’s specific references to “counsel[ing]” in a separate Church
8 Amendment provision, “training” in the Coats-Snowe Amendment, and “refer for” in the Weldon
9 Amendment demonstrate Congress’s intent to keep these actions separate in meaning from
10 “assist[ing] in the performance.”

11 “Health care entity” is defined in the Coats-Snowe Amendment and the Weldon
12 Amendment, yet the Rule expands the definition to include “health care personnel,” as distinct
13 from a “health care professional,” such as a doctor, nurse or other licensed medical provider.⁷
14 Thus, the Rule suggests significantly broader categories of personnel could refuse to provide
15 services—potentially including even a receptionist making an appointment for a patient.

16 The term “health care entity” is expanded to include “a plan sponsor, issuer, or third-party
17 administrator, or any other kind of health care organization, facility, or plan.” 84 Fed. Reg. at
18 23264. This definition allows broad categories of individuals and entities, even those with no
19 ethical obligation to the patient or involvement in direct patient care, to deny healthcare.

20 The Rule’s definition of “referral or refer for” includes “the provision of information in
21 oral, written, or electronic form (including names, addresses, phone numbers, email or web
22 addresses, directions, instructions, descriptions, or other information resources), where the

23 _____
24 ⁷ Compare 42 U.S.C. § 238n(c)(2) (defining “health care entity” to include “an individual
25 physician, a postgraduate physician training program, and a participant in a program of training in
26 the health professions”) and P.L. 115-245, the Department of Defense and Labor, Health and
27 Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act,
28 2019 (H.R. 6157), Div. B, sec. 507(d)(2) (defining “health care entity” to include “an individual
physician or other health care professional, a hospital, a provider-sponsored organization, a health
maintenance organization, a health insurance plan, or any other kind of health care facility,
organization, or plan”) with 84 Fed. Reg. at 23264 (defining “health care entity” to include
“health care personnel” and describing listed entities included in the definition as “illustrative, not
exhaustive”).

1 purpose or reasonably foreseeable outcome of provision of the information is to assist a person in
2 receiving funding or financing for, training in, obtaining, or performing a particular health care
3 service, program, activity, or procedure.” Thus, under the Rule, even the posting of notices,
4 would be considered a “referral.” 84 Fed. Reg. at 23264.

5 **II. CALIFORNIA LAWS BALANCE GUARANTEEING ACCESS TO HEALTHCARE WHILE** 6 **PROTECTING CONSCIENCE**

7 With over 39 million residents, California is the nation’s most populous state. Sturges Dec.
8 ¶ 5. Ensuring access to healthcare is a key element in shaping overall health and well-being of
9 California residents, and is therefore a critical component of the State’s public health programs
10 and laws. California laws carefully balance conscience protections with Californians’ right to full
11 and equal access to healthcare. *See e.g.*, Cal. Prob. Code § 4736 (permitting a healthcare provider
12 to decline a healthcare decision for reasons of conscience, but requiring notification to the patient,
13 assistance in transfer, and continuing care until transfer); Cal. Bus. & Prof. Code § 733 (a
14 healthcare licentiate “shall not obstruct a patient in obtaining a prescription drug or device,” but
15 providing a process for the licentiate to decline with advance written notice to the employer if a
16 reasonable accommodation can be offered without undue hardship, while ensuring timely
17 prescriptions to the patient); *see also* Aizuss Dec. ¶¶ 17-22, 26-29 (recognizing existing laws
18 already balance patients’ rights with physicians’ conscience rights).

19 California laws also protect patients from discrimination in healthcare, including through
20 the state’s regulation of its licensed healthcare professionals. Cal. Bus. & Prof. Code § 125.6 (a
21 licensed healthcare professional is subject to discipline if he or she refuses or aids in the refusal of
22 licensed activities on the basis of sex, race, color, religion, ancestry, national origin, disability,
23 medical condition, genetic information, marital status, sexual orientation, citizenship, primary
24 language, or immigration status). California’s Unruh Civil Rights Act, Civil Code sections 51 *et*
25 *seq.*, also bars business establishments from discriminating in the delivery of services and goods,
26 including discrimination based on sex, which includes gender identity and gender expression.
27
28

1 Cal. Civ. Code § 51(b);⁸ *N. Coast Women’s Care Med. Group, Inc. v. San Diego Cty. Superior*
 2 *Court*, 44 Cal. 4th 1145, 1158 (2008).

3 With respect to reproductive health, California laws require healthcare coverage for
 4 maternity services (Cal. Health & Safety Code §§ 1345, 1367(i); Cal. Code Regs., tit. 28,
 5 § 1300.67; Cal. Ins. Code §§ 10123.865, 10123.866), support procreative choice (Cal. Health &
 6 Safety Code § 123462(b)), and—consistent with the Affordable Care Act’s Women’s Health
 7 Amendment (42 U.S.C. § 300gg-13(a)(4))—require coverage of all Food and Drug
 8 Administration (FDA)-approved drugs, devices, and other products for women (Cal. Health &
 9 Safety Code § 1367.25; Cal. Ins. Code § 10123.196(b)(1)). But a religious employer may request
 10 a health care service plan contract that does not cover FDA-approved contraceptive methods that
 11 are contrary to the religious employer’s religious tenets. Cal. Health & Safety Code § 1367.25(c);
 12 Cal. Ins. Code § 10123.196(e); *see also* Cal. Penal Code §§ 13823.11(e)(1); (e)(2), (g)(4)(A),
 13 (g)(4)(B); Cal. Health & Safety Code § 1281 (requiring pregnancy prevention treatment for
 14 sexual assault survivors, but also establishing an advance accommodation process for hospitals).
 15 And no employer shall require a licensed provider to participate in an abortion “if the employee or
 16 other person has filed a written statement with the employer or the hospital, facility, or clinic
 17 indicating a moral, ethical, or religious basis for refusal to participate.” Cal. Health & Safety
 18 Code §§ 123420(a), 123466. To balance this exemption with the needs of the patient, this
 19 provision does not apply to “medical emergency situations” and miscarriages. Cal. Health &
 20 Safety Code § 123420(d); Cal. Health & Safety Code §§ 1317(a), (e).

21 **III. CALIFORNIA’S SOVEREIGNTY AND FEDERAL FUNDS ARE TARGETED BY THE RULE**

22 The Rule explicitly targets California and its laws and policies balancing conscience
 23 protections and patient rights.⁹ The Rule states that it seeks to resolve confusion caused by
 24 OCR’s “high-profile” closing of three Weldon Amendment complaints against California. 84

25 ⁸ “For purposes of this section . . . ‘Sex’ includes. . . pregnancy, childbirth, or medical conditions
 26 related to pregnancy or childbirth. ‘Sex’ also includes, but is not limited to, a person’s gender.
 27 ‘Gender’ means sex, and includes a person’s gender identity and gender expression. ‘Gender
 28 expression’ means a person’s gender-related appearance and behavior whether or not
 stereotypically associated with the person’s assigned sex at birth.” Cal. Civ. Code § 51(e)(5).

⁹ Indeed, the Rule mentions California no less than 44 times. *See generally* 84 Fed. Reg. 23170.

1 Fed. Reg. at 23178-23179. The three complaints,¹⁰ which were filed by a religious organization,
2 churches and a church-run school, and employees of a religiously affiliated university, alleged
3 that the Department of Managed Health Care (DMHC) (the California agency responsible for
4 regulating managed care health plans) contacted seven health plans on August 22, 2014 about
5 their offering products without abortion coverage, and requiring those health plans to include
6 abortion coverage.¹¹

7 On June 21, 2016, OCR closed the three complaints in favor of California, finding that the
8 Weldon Amendment was not violated because the seven health plans that received the letter had
9 not objected to providing such coverage on religious or moral grounds, which is a requirement for
10 protection under the Weldon Amendment. Palma Dec. Ex. B, letter from OCR to complainants.
11 Additionally, OCR noted that after receipt of DMHC's August 22, 2014 letter, the health plans
12 voluntarily modified their health products. *Id.* Citing *NFIB v. Sebelius*, 567 U.S. 519 (2012),
13 OCR determined that this approach avoided a "potentially unconstitutional" application of
14 Weldon, given Weldon's consequence to rescind "all funds appropriated under the
15 Appropriations Act to the State of California—including funds provided to the State not only by
16 HHS but also by the Departments of Education and Labor, as well as other agencies." *Id.* OCR
17 also noted that one of the health plans received an exemption to allow it to offer a plan product
18 excluding abortion services for "religious employers" as defined under California Health and
19 Safety Code section 1367.25(c)(1). *Id.*

20 But on August 30, 2018, OCR informed California that it had reviewed a September 2017
21 complaint based on the closed DMHC complaints and determined that OCR had sufficient
22 authority and cause to investigate the allegations under the Weldon, Coats-Snowe, and Church
23 Amendments, thus reopening the previously closed investigation. The Rule states that HHS and
24 OCR no longer agree with OCR's prior interpretation of the Weldon Amendment expressed in the
25 June 21, 2016 finding in favor of California. 84 Fed. Reg. at 23179. The Rule states that HHS

26 _____
27 ¹⁰ OCR Complaint Nos. 14–193604, 15–193782, and 15–195665.

28 ¹¹ DMHC explained in its August 22, 2014 letter that the Knox-Keene Act requires the provision of basic healthcare services and the California Constitution prohibits health plans from discriminating against women who choose to terminate a pregnancy.

1 “continues to hold the views it expressed” in the NPRM, *id.*, which noted that despite the
 2 constitutional concerns cited in OCR’s June 21, 2016 letter, HHS nonetheless remained obligated
 3 “to not make certain funding available to covered entities that discriminate in violation of the
 4 Weldon Amendment.” 83 Fed. Reg. at 3890.

5 The promulgation of the Rule sets up an unavoidable conflict between OCR and California
 6 by expanding the scope of the Weldon protection to *any* reason for refusing such coverage, not
 7 just religious and moral objections. Although “health care entity” is defined by the Weldon
 8 Amendment (and the Coats-Snowe Amendment), the Rule illegally broadens the definition to
 9 include “a plan sponsor, issuer, or third party administrator,” thus allowing an employer, as
 10 expressly stated by the Rule, to deny coverage for reproductive services to its employees.

11 On top of the reopening of the DMHC investigation, on January 17, 2019, OCR issued a
 12 letter to California entitled a Notice of Violation, regarding California’s Reproductive FACT Act,
 13 and concluded that California had violated the Weldon Amendment and the Coats-Snowe
 14 Amendment.¹² Palma Dec. Ex. C, notice of violation.

15 **IV. THE CALIFORNIA FUNDING AND PROGRAMS AT RISK UNDER THE RULE**

16 California receives billions of dollars in federal funds largely under the Labor, Health and
 17 Human Services Appropriations Act for labor, education, and health and human services Sturges
 18 Dec. ¶ 7; Ghaly Dec. ¶ 9; Toche Dec. ¶ 12; Palma Dec. Ex. A, 2018-19 Cal. Dep’t. Educ. Budget,
 19 at 9-12. Some of these federal dollars support programs run by state agencies and some funds are
 20 passed on to local governments and other sub-grantees. Sturges Dec. ¶ 8; Ghaly Dec. ¶ 8.

21 The California Health & Human Services Agency (CHHS) expects to receive \$77.6 billion
 22 in federal funding for fiscal year 2019-2020 (almost half of its budget), and the Rule places at risk
 23 federal funds from HHS. Ghaly Dec. ¶ 8; *see* 84 Fed. Reg. at 23177, 23262 (section 88.6(d)(iii)
 24 of the Rule makes clear that an OCR “determination of noncompliance [will be used] to inform

25 ¹² As a sign of Defendants’ arbitrary targeting of California, this notice of violation notes that
 26 California’s Attorney General wrote OCR stating that “[G]iven the status of pending litigation
 27 regarding the [FACT] Act, this office has no plans to enforce the Act against any facility.” *See*
 28 *generally NIFLA v. Becerra*, 138 S. Ct. 2361 (2018) (concluding that the plaintiffs were likely to
 succeed on their claim that the FACT Act violated the First Amendment). Yet Hawaii’s virtually
 identical response to OCR’s investigation of a comparable law passed Hawaii were “resolved
 without having to find Hawaii in violation.” 84 Fed. Reg. at 23177.

1 [HHS's] decision whether to approve, renew, or modify Federal funding to the recipient," and the
2 Rule notes that OCR has already made a determination of noncompliance against California).
3 CHHS programs provide critical healthcare services, social services, mental health services,
4 alcohol and drug abuse services, income assistance, and public health services to Californians
5 from all walks of life. Ghaly Dec. at ¶¶ 2, 5. At risk are federal funds like the approximately \$63
6 billion the Department of Health Care Services (DHCS) received in the 2018-19 State Fiscal
7 Year. *Id.* at ¶¶ 11-12; Cantwell Dec. at ¶¶ 2, 7. DHCS administers and oversees multiple
8 federally-funded programs providing healthcare services for *one-third of Californians*, including
9 Medicaid, the Children's Health Insurance Program, and several other health-related federal
10 grants programs. Cantwell Dec. at ¶¶ 2, 7; Ghaly Dec. ¶ 12.

11 The Rule puts at risk about \$1.5 billion for the California Department of Public Health.
12 Nunes Dec. ¶¶ 9, 12, 16, 19; Ghaly Dec. ¶¶ 16-18. These funds support programs related to
13 emergency preparedness, chronic and infectious disease prevention including vaccinations and
14 STD control, environmental health programs, healthcare facility licensing programs, and
15 programs helping the state address the opioid crisis, among others. Nunes Dec. ¶¶ 5, 9, 12, 16,
16 19; Ghaly Dec. ¶¶ 16-1. The Rule also jeopardizes funding for the California Department of
17 Social Services (CDSS), including nearly \$2.5 billion for various child welfare and refugee
18 assistance programs and \$6 billion for the In-Home Supportive Services program which helps
19 provide care and support for California's seniors and people with disabilities, among others.
20 Ghaly Dec. ¶ 14; Cervinka Dec. ¶¶ 7, 9-13. The Rule may also impact \$4.2 million for mental
21 health services provided through the Department of State Hospitals (DSH). Price Dec. ¶ 14. The
22 Rule also places at risk the federal share of over \$89 million California Correctional Health Care
23 Services (CCHCS) receives annually to support the current level of healthcare by civil service
24 and contracted staff and facilities to the inmate population of the California Department of
25 Corrections and Rehabilitation. Toche Dec. ¶ 12.

26 The Rule also places at risk funding from the U.S. Department of Labor, including funding
27 to support employment programs under Title III of the Social Security Act, (unemployment
28 insurance programs), the Workforce Innovation and Opportunity Act, the Occupational Safety

1 and Health Act, and the Jobs for Veterans State grants program under 38 U.S.C. § 4102A(b)(5).
2 Sturges Dec. ¶¶ 7-9. The California Unemployment Development Department expects to receive
3 nearly \$900 million in fiscal year 2018-2019 to provide short-term income to unemployed
4 individuals, fund local workforce development boards, and provide services to job seekers and
5 employers. *Id.* at ¶¶ 5, 8. The California Department of Industrial Relations expects to receive
6 \$38 million in fiscal year 2018-2019 to protect occupational health and safety, promote
7 apprenticeships, and promote labor standards. *Id.* at ¶¶ 8-9.

8 The California Department of Education expects to receive \$3.8 billion in federal funding
9 in fiscal year 2018-19 to support instruction, including migrant education, adult education,
10 education for homeless children, special education, and vocational education; \$584 million for
11 instructional support, including curriculum services and wellness in education programs; and \$3.8
12 billion for special programs, including child care and state preschool programs. Palma Dec. Ex.
13 A, 2018-19 Cal. Dep't. Educ. budget, at 11-12.

14 California's public colleges and universities receive hundreds of millions of dollars in
15 funding for education, including for the largest system of higher education in the nation, and for
16 medical and scientific research from the National Institutes of Health and the Centers for Disease
17 Control and Prevention. Harris-Caldwell Dec. ¶ 2; Parmelee Dec. ¶¶ 4-9; Dkt. No. 1 at 37-38.

18 LEGAL STANDARD

19 To obtain a preliminary injunction, the plaintiff must demonstrate that (1) it "is likely to
20 succeed on the merits," (2) it "is likely to suffer irreparable harm in the absence of preliminary
21 relief," (3) "the balance of equities tips in [its] favor," and (4) "an injunction is in the public
22 interest." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). Courts evaluate these
23 factors on a "sliding scale approach," such that serious questions going to the merits and a
24 balance of hardships that tips sharply towards the plaintiff can support issuance of preliminary
25 relief, so long as the plaintiff also shows that there is a likelihood of irreparable injury and that the
26 injunction is in the public interest." *Arc of Cal. v. Douglas*, 757 F.3d 975, 983 (9th Cir. 2014).
27 The APA also provides that "the reviewing court [...] may issue all necessary and appropriate
28 process to postpone the effective date of an agency action." 5 U.S.C. § 705. This remedy is

1 available “to the extent necessary to prevent irreparable injury” and to preserve the status quo
 2 pending judicial review proceedings. *Id.*; *Nken v. Holder*, 556 U.S. 418, 425 (2009).

3 ARGUMENT

4 I. CALIFORNIA IS LIKELY TO SUCCEED ON THE MERITS

5 A. The Rule Is Invalid Under the APA

6 The Rule must be held “unlawful and set aside” because it is “not in accordance with the
 7 law” and is “in excess of statutory jurisdiction.” 5 U.S.C. §§ 706(2)(A), 706(2)(C). Here,
 8 Congress did not delegate to Defendants the ability to promulgate a rule that puts billions of
 9 dollars at risk and undercuts access to healthcare. *Michigan v. EPA*, 268 F.3d 1075, 1081 (D.C.
 10 Cir. 2001) (an agency’s rulemaking power is limited to the authority delegated to it by Congress).
 11 Moreover, the Rule is arbitrary and capricious because Defendants have failed to “give adequate
 12 reasons for [their] decisions” and therefore “cannot carry the force of law.” *Encino Motorcars,*
 13 *LLC v. Navarro*, 136 S. Ct. 2117, 2125 (2016); *see supra* Section I(B)(1). This makes the Rule
 14 “procedurally defective” and, as such, the court need not even reach California’s other challenges,
 15 including whether the agency has exceeded its authority in order to set aside the agency action.
 16 *Encino Motorcars*, 136 S. Ct. at 212; *see also Am. Bar Ass’n v. U.S. Dep’t of Educ.*, 370 F. Supp.
 17 3d 1, 33-34 (D.D.C. 2019).

18 1. The Rule Is in Excess of Statutory Jurisdiction

19 Defendants have acted in excess of statutory authority by conferring broad enforcement
 20 powers to OCR without statutory basis, and by granting themselves authority to alter statutory
 21 definitions in a manner inconsistent with statute. Federal agencies, “literally [have] no power to
 22 act . . . unless and until Congress confers power upon” them. *La. Pub. Serv. Comm’n v. FCC*,
 23 476 U.S. 355, 374 (1986); 5 U.S.C. § 706(2)(C). In determining whether Defendants exceeded
 24 their statutory authority, the court must first ascertain whether the statute “has directly spoken to
 25 the precise question at issue”; if the statute is unambiguously clear, “that is the end of the matter.”
 26 *Chevron*, 467 U.S. at 842-843. Second, if the statute admits of some ambiguity, then courts must
 27 determine whether the agency’s interpretation is “reasonable” by applying normal canons of
 28 statutory construction, looking not only to the law’s text, but also to its structure, purpose, and

1 legislative history. *Id.* at 844. Agency interpretation is unreasonable if it conflicts with the
2 statute. *Ragsdale v. Wolverine World Wide, Inc.*, 535 U.S. 81, 95-96 (2002).

3 Although the Rule proposes to enforce over two dozen statutes, only one statute speaks
4 directly to the HHS’s power to enforce. Section 1553 of the Affordable Care Act (ACA) states:
5 “The Office for Civil Rights of the Department of Health and Human Services is designated to
6 receive complaints of discrimination based on this section.” 42 U.S.C. § 18113(d). The plain text
7 of the statute only confers onto OCR the power to receive complaints of discrimination. There is
8 no directly granted authority—under Section 1553 or any other federal conscience law—for
9 “robust” use of enforcement tools that could halt funding or suspend award activities. 84 Fed.
10 Reg. 23254. Yet the Rule purports to expand OCR’s enforcement authority to do precisely that.
11 *See* 84 Fed. Reg. 23271-72 (to be codified at Section 88.7(i)(3)(i)-(vii)) (allowing OCR to effect
12 compliance by withholding, suspending, and terminating federal funding or suspending award
13 activities).

14 Agency action also fails under step one of a *Chevron* test when the agency attempts to alter
15 or add additional criteria beyond those in the governing statute. *Cent. United Life Ins. Co. v.*
16 *Burwell*, 827 F.3d 70, 72–73 (D.C. Cir. 2016) (rejecting a rule that amended the *statutory* criteria
17 for fixed indemnity insurance). The Rule’s implementation of specific penalties for
18 noncompliance with two dozen laws, 84 Fed. Reg. at 23272, is unmoored from any statutory text.
19 Although the Weldon Amendment purports to strip noncompliant entities of broad categories of
20 federal funding (which raises its own legal problems), nothing in the Weldon Amendment, or
21 elsewhere in federal law, supports the separate, discretionary enforcement mechanisms asserted in
22 the Rule. *See* P.L. 115-245, the Department of Defense and Labor, Health and Human Services,
23 and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 (H.R. 6157),
24 Div. B, sec. 507(d)(1); 84 Fed. Reg. 23254. Additionally, Defendants have offered no authority
25 to suggest that the Weldon Amendment allows Defendants to use the Weldon Amendment’s
26 enforcement mechanisms to enforce other, separate statutes.

27 Agency action may be deemed unreasonable at *Chevron* step two if it would bring about
28 “an enormous and transformative expansion in [the agency’s] regulatory authority” without clear

1 congressional authorization. “When an agency claims to discover in a long-extant statute an
2 unheralded power to regulate a significant portion of the American economy, we typically greet
3 its announcement with a measure of skepticism. We expect Congress to speak clearly if it wishes
4 to assign to an agency decisions of vast economic and political significance.” *Util. Air*
5 *Regulatory Grp. v. EPA*, 134 S. Ct. 2427, 2444 (2014). Here, Congress has not assigned to HHS
6 authority to transform the delivery of healthcare to patients and to decide how two dozen statutes
7 (including some dating back half a century) are defined and implemented—and Congress
8 certainly has not done so “clearly.” In seeking “an enormous and transformative expansion in
9 [administrative] regulatory authority” without clear statutory basis, *id.*, the Rule exceeds statutory
10 authority.

11 **2. The Rule Is Contrary to Several Federal Statutes**

12 Because the Rule creates barriers to obtaining healthcare, impedes timely access to
13 healthcare, and encourages discrimination, it cannot be reconciled with ACA sections 1554 and
14 1557. The Rule also conflicts with the Emergency Medical Treatment & Labor Act (EMTALA).

15 **a. The Rule Conflicts with Section 1554 of the ACA**

16 Congress prohibits the Secretary of HHS from promulgating any regulation that “(1) creates
17 any unreasonable barriers to the ability of individuals to obtain appropriate medical care; (2)
18 impedes timely access to health care services; (3) interferes with communications regarding a full
19 range of treatment options between the patient and provider; (4) restricts the ability of health care
20 providers to provide full disclosure of all relevant information to patients making health care
21 decisions; [or] (5) violates the principles of informed consent and the ethical standards of health
22 care professionals.” 42 U.S.C. § 18114. But here, the Rule creates barriers and impedes access to
23 healthcare for women (including in emergencies), people with disabilities, LGBTQ individuals,
24 as well as residents of rural communities. *See infra* Section I(B)(3). Such barriers violate section
25 1554. *See California v. Azar*, 19-cv-01184-EMC, 2019 WL 1877392, at *24 (N.D. Cal. Apr. 26,
26 2019) (HHS likely violated Section 1554 where Title X rule “obfuscate[s] and obstruct patients
27 from receiving information and treatment for their pressing medical needs”).

28 ///

1 Defendants justify their actions by citing a White Paper claiming there is “insufficient
2 evidence to conclude that conscience protections have negative effects on access to care.” 84
3 Fed. Reg. at 23251, n.345. But this White Paper actually details the dangers of decreased access
4 caused by denials of care, including the death of patients. Palma Dec. Ex. D at S45-48. It also
5 recommends taking steps to process objections to help with accompanying obligations of
6 providers who assert them, “such as disclosure to employers and patients, and duties to refer, to
7 impart accurate information, to provide urgently needed care and to reduce or eliminate refusal as
8 an option for the care of ectopic pregnancy, inevitable spontaneous abortion, rape, and maternal
9 illness,” steps which the Rule neglected. *Id.* at S53. Not only does the Rule fail to implement
10 these obligations, it affirmatively prohibits them. The overwhelming evidence demonstrates that
11 the Rule will impede timely access to care and impose unreasonable barriers. Cantwell Dec. ¶ 8;
12 Lara Dec. ¶ 10; Zahn Dec. ¶ 8; Harris-Caldwell Dec. ¶¶ 13-15.

13 **b. The Rule Violates the ACA’s Nondiscrimination Provision**

14 The Rule is also unlawful because it permits providers to exclude patients from full and
15 equal healthcare benefits and services, and permits providers and other healthcare personnel to
16 discriminate on the basis of sex and disability. Section 1557 of the ACA prohibits discrimination
17 under any health program or activity on the basis of classifications listed in four federal civil
18 rights statutes—Title VI of the Civil Rights Act of 1964 (race, color, national origin, and sex),
19 Section 504 of the Rehabilitation Act of 1973 (disability), Title IX of the Education Amendments
20 (sex), and the Age Discrimination Act of 1975 (age). 42 U.S.C. § 18116(a); 20 U.S.C. § 1681(a);
21 45 C.F.R. § 92.1; *see also Ferrer v. CareFirst, Inc.*, 265 F.Supp. 3d 50, 52-54 (D.D.C. 2017)
22 (denial of full coverage resulting in women paying out of pocket for lactation services violates the
23 ACA); Commission Decision on Coverage of Contraception, EEOC 2000 WL 33407187 (Dec.
24 14, 2000) (coverage for preventive services but not contraception is sex discrimination); *see also*
25 Zahn Dec., Ex. A (cautioning that conscience refusals should be evaluated because of their
26 potential for discrimination).

27 But here, the Rule emboldens providers, insurers, plan sponsors (i.e., employers) and other
28 healthcare personnel and entities to exempt themselves from providing a broad range of benefits

1 and services—including contraceptives (84 Fed. Reg. at 23176 (*citing Hellwege v. Tampa Family*
 2 *Health Ctrs.*, 103 F. Supp. 3d 1303 (M.D. Fla. 2015)), emergency miscarriage management (*id.* at
 3 n.27 (*citing Means v. U.S. Conference of Catholic Bishops*, No. 1:15-CV-353, 2015 WL 3970046
 4 (W.D. Mich. June 30, 2015))), tubal ligations and hysterectomies (but not vasectomies) (*id.*), and
 5 gender dysphoria and gender transition services (*id.* (*citing Minton v. Dignity Health*, No. 17–
 6 558259 (Cal. Super. Ct. Apr. 19, 2017)))—to women and to the LGBTQ community. Several
 7 organizations advocating for the rights of disabled individuals, also objected to the NPRM
 8 because it will promote discrimination on the basis of disability. For example, they cite to
 9 discrimination against individuals with HIV or persons who, due to their disabilities, are more
 10 likely to live in provider-controlled settings and/or are more dependent on medical personnel to help
 11 coordinate care. Palma Dec. Ex. N, Nat. Assoc. Councils Dev. Disabilities; Ex. T, Consortium for
 12 Citizens with Disabilities; Ex. U, Disabilities Rights Educ. & Def. Fund; Ex. V, Disability
 13 Coalition N.M. And whereas the prior rules confirmed that discrimination is “outside the scope”
 14 of conscience laws, the Rule includes no such assurance. 73 Fed. Reg. at 78080; 76 Fed. Reg. at
 15 9973-74. The Rule’s encouragement of discrimination directly violates Section 1557.

16 c. The Rule Violates EMTALA

17 The Rule conflicts with EMTALA, which requires all Medicaid and Medicare participating
 18 hospitals with emergency rooms to provide an “appropriate medical screening examination” to
 19 determine “whether or not an emergency medical condition . . . exists.” 42 U.S.C. § 1395dd(a).
 20 If there is an emergency medical condition¹³, the hospital *must* treat the patient to the point of
 21 stabilization, or transfer her to another facility. *Id.* at § 1395dd(b)(1). If the condition is not
 22 stabilized, the hospital may not transfer the patient unless a physician signs a certification
 23 weighing the risks of transfer. *Id.* at § 1395dd(c)(1); *see also* Aizuss Dec. ¶ 27.

24 _____
 25 ¹³ An “emergency medical condition” is one “manifesting itself by acute symptoms of sufficient
 26 severity (including severe pain) such that the absence of immediate medical attention could
 27 reasonably be expected to result in—(i) placing the health of the individual (or, with respect to a
 28 pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious
 impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part . . .” 42
 U.S.C. § 1395dd(e)(1). An “emergency medical condition” also exists if there is no time to
 transfer a pregnant woman before delivery, or the “transfer may pose a threat to the health or
 safety of the woman or the unborn child.” *Id.*

1 The Rule is inconsistent with Congress’s directive in EMTALA—to prevent patients in
2 need of emergency care from being turned away. *Jackson v. East Bay Hosp.*, 246 F.3d 1248,
3 1254 (9th Cir. 2001). Under the Rule, emergency personnel may refuse to provide medically
4 indicated and requested care. As an example of “discrimination,” the Rule refers to a scenario in
5 which a hospital denied emergency medical care to a woman who experienced pregnancy
6 complications likely to result in fetal death or stillbirth and risk of injury or death to the woman if
7 she continued her pregnancy. 83 Fed. Reg. at 3888, n.36, 3889; 84 Fed. Reg. 23176, n.27 (*citing*
8 *Means v. U.S. Conference of Catholic Bishops*, No. 1:15-CV-353, 2015 WL 3970046 (W.D.
9 Mich. June 30, 2015)). Defendants also cite an American College of Obstetricians and
10 Gynecologists (ACOG) ethics opinion outlining providers’ obligation to provide emergency
11 care—apparently as a further example of the kind of “discrimination” the Rule is designed to
12 address. *See* 83 Fed. Reg. at 3888; *see also* 84 Fed. Reg. at 23176, n.28.¹⁴

13 But, contrary to the Rule, courts construing federal conscience protections have noted that a
14 balancing test is necessary in cases of emergency care: there is no indication “from the express
15 language of the Weldon Amendment...that enforcing...EMTALA [or California’s equivalent law]
16 to require medical treatment for emergency medical conditions would be considered
17 ‘discrimination’ under the Weldon Amendment if the required medical treatment was abortion-
18 related services.” *See e.g., California v. United States*, No. C 05-00328, 2008 WL 744840, at *4
19 (N.D. Cal. Mar. 18, 2008); *see also* Cal. Health & Safety Code § 123420(d).¹⁵

20 Yet in response to concerns that the Rule conflicts with EMTALA, Defendants assert only
21 that “OCR intends to read every law passed by Congress in harmony to the fullest extent possible
22 so that there is maximum compliance with the terms of each law.” 84 Fed. Reg. at 23183
23 (neglecting to include any exceptions to the Rule or explanation to providers of how to comply
24 with the Rule and EMTALA). This vague and conclusory statement gives little comfort when the
25 Rule’s expansive definitions, including the Rule’s definitions of “assist in the performance” of

26 ¹⁴ *See* full ACOG opinion at Exhibit A to Zahn Dec.

27 ¹⁵ *See also* 151 Cong. Rec. H176-77 (Jan. 25, 2005) (statements by Rep. Weldon acknowledging
28 requirements of EMTALA and noting that Weldon prohibits coercion in “nonlife-threatening
situations,” but when the “mother’s life is in danger a health care provider must act to protect the
mother’s life.”).

1 and “referral” could, contrary to EMTALA, protect providers who turn away a patient needing
2 emergency care.

3 **B. The Rule Is Arbitrary and Capricious and Thus Invalid Under the APA**

4 A rule is arbitrary and capricious if the agency has “entirely failed to consider an important
5 aspect of the problem,” “offered an explanation for its decision that runs counter to the evidence
6 before the agency,” or “is so implausible that it could not be ascribed to a difference in view or
7 the product of agency expertise.” *Motor Vehicle Mfrs. Ass’n of U.S., Inc. v. State Farm Mut.*
8 *Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). Where an agency departs from a prior policy, it must
9 “display awareness that it is changing position,” show that “there are good reasons” for the
10 reversal, and demonstrate that its new policy is “permissible under the statute.” *F.C.C. v. Fox*
11 *Television Stations, Inc.*, 556 U.S. 502, 515 (2009). A more “detailed justification” is needed
12 when “serious reliance interests” are at stake. *Id.* The Rule fails for all these reasons.

13 **1. Defendants Failed to Reasonably Explain Their Policy Reversal**

14 The Rule effects a significant change in policy from the 2011 rule that will impact the
15 delivery of healthcare nationwide and how programs accepting federal funds are administered.
16 The Rule relies largely on a purported spike in complaints; however, this justification is
17 unsupported and is insufficient, especially given the number of regulated entities and individuals
18 relying on the existing 2011 rule (and in opposition to the Rule). Defendants admit that OCR has
19 received only 44 complaints over the last 10 years of alleged instances of violations of conscience
20 rights. 83 Fed. Reg. at 3886.¹⁶ Also, there is nothing in the recitation of OCR’s closure of the ten
21 complaints prior to the 2016 election that suggests that OCR’s enforcement is in anyway deficient
22 and in need of major overhaul. 83 Fed. Reg. 3886. An administration change does not authorize
23 an unreasoned reversal of course. *State v. U.S. Bureau of Land Mgmt.*, 277 F. Supp. 3d 1106,
24 1123 (N.D. Cal. 2017) (a new administration must give reasoned explanations for a policy change
25 and address the findings underpinning a prior rule). Thus, a purported surge in complaints and
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28 ¹⁶ Although Defendants report receiving 343 complaints in 2018, 84 Fed. Reg. at 23229, they
have failed to comply with FOIA requests for records of complaints. Dkt. No. 1 at 40-43.

1 complaint closures to date leading up to the NPRM cannot serve as any reasoned basis for such a
2 dramatic policy reversal.

3 Defendants' justification that the Rule will increase access to healthcare is also
4 unsubstantiated and runs counter to the evidence available in the record. Defendants say that they
5 "expect[] any decrease in access to care to be outweighed by significant overall increases in
6 access generated" by the Rule because the Rule will allow objecting practitioners to continue in
7 the practice of medicine (or to enter the field). 84 Fed. Reg. at 23252. The sole evidence
8 Defendants present to buttress this claim is a survey conducted in 2009.¹⁷ Defendants' use of this
9 data is problematic in several ways. First, the results are non-representative as the survey was
10 offered online only to members of five religious medical groups.¹⁸ Second, the data is a decade
11 old. A summary memo prepared by the polling company includes the disclaimer that the
12 respondents who participated in the survey "were self-selecting" and that the survey "is not
13 intended to be representative of the entire medical profession nor of the entire membership rosters
14 of these organizations." *Cf. Int'l Rehabilitative Scis., Inc., v. Sebelius*, 688 F.3d 994, 1002-04
15 (9th Cir. 2012) (upholding HHS's decision after the agency weighed scientific studies that ran
16 counter to the agency's decision, and finding they contained methodological deficiencies).¹⁹
17 Finally, the survey's results are out of context: they were obtained in the wake of the proposed
18 rescission of the 2008 rule. Over 80 percent of respondents said that it was either "very" or
19 "somewhat" likely that they would limit the scope of their practice of medicine if the 2008 rule
20 was replaced.²⁰ And it appears that the question posed to the respondents may have been
21 misleading, in that it suggested that a rescission of the 2008 rule would leave providers with no
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23

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25 ¹⁷ The Rule cites the same 2009 survey in two different ways: a summary memo dated April 8,
26 2009, Palma Dec. Ex. F (cited in n.316), and an undated document that combines the 2009
27 results with a 2011 poll of the general public, Palma Dec. Ex. E (cited in n.309, 322, 340, 347,
28 349).

¹⁸ Palma Dec. Ex. F, April 8, 2009 summary memo.

¹⁹ *Id.*

²⁰ *Id.*

1 protections in the abortion context.²¹ To the contrary of the survey’s purported predictions, there
 2 is no evidence of an exodus from the medical profession after the rescission of the 2008 rule in
 3 February 2011. Indeed, Defendants themselves point out that religious providers such as
 4 Ascension, the “nation’s largest religiously affiliated non-profit health care system” are thriving
 5 and providing approximately \$2 billion in care, equal to Kaiser Permanente.²² 84 Fed. Reg. at
 6 23248. Moreover, the nation’s trusted major medical organizations raised grave concerns about
 7 the legality and reasonableness of the proposed regulation. *See* ECF No. 1 at 17-20; Aizuss Dec.
 8 generally. Therefore, the 2009 survey is shoddy foundation on which to build a Rule of such
 9 broad scope and impact on patients’ access to healthcare. HHS’s determination that the Rule will
 10 increase access “runs counter to the evidence before the agency” and is therefore arbitrary and
 11 capricious. *State Farm*, 463 U.S. at 43; *see also California*, 2019 WL 1877392 at *38 (rejecting
 12 Defendants’ unsubstantiated claims that other providers are “waiting in the wings” to fill the void
 13 left by their Title X rule).

14 Despite the substantial amounts of funding and critical programs at risk, Defendants have
 15 failed to engage in reasoned decisionmaking, relying instead on conclusory and unsubstantiated
 16 statements, as well as an outdated study concerning the Rule’s alleged public benefits. Given the
 17 “serious reliance interests at stake,” Defendants’ “conclusory statements do not suffice to explain
 18 its decision.” *Encino Motorcars*, 136 S. Ct. at 2127.

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 22 ²¹ *Id.* at 2 (summarizing the inquiry posed to respondents as follows: “Without any names or
 23 political parties being mentioned, respondents were provided with a short description of the new
 24 conscience protection law and its recent inception: ‘**Just two months ago, a federal law known as ‘conscience protection’ went into effect after reports of doctors being discriminated against for declining to perform abortions. It protects doctors and other medical professionals who work at institutions that receive federal money from performing medical procedures to which they object on moral or religious grounds.**’) (emphasis in original).

25
 26 ²² Also, employment in the healthcare has increased steadily, with a gain of about 2.3 million
 27 employees by January 2019 since the publication of the current regulations in February 2011.
 28 U.S. Bureau of Labor Statistics, Employment, Hours, and Earnings from the Current Employment
 Statistics survey (National), All employees, thousands, education and health services, seasonally
 adjusted, accessed through <https://beta.bls.gov/dataQuery/search>.

2. The Rule’s Stance on Title VII is Illogical in its Own Terms

The Rule creates an unworkable inconsistency with Title VII of the Civil Rights Act of 1964. It seeks to replace Title VII’s well-established religious accommodation process with a different standard for a segment of the healthcare industry as to a subset of medical procedures deemed to be under the Rule’s umbrella.²³ But the Rule raises too many uncertainties about when and how the alternative accommodation process will work, which demonstrates that the Rule was not the product of reasoned and logical decisionmaking. If an agency’s decision is “illogical on its own terms,” that decision is arbitrary and capricious. *Am. Fed’n of Gov’t Employees, Local 2924 v. Fed. Labor Relations Auth.*, 470 F.3d 375, 380 (2006).

Title VII (which applies to employers with 15 or more employees) makes it unlawful for employers to discriminate against any individual with regard to his or her compensation, terms, conditions, or privileges of employment, based on that employee’s religion. 42 U.S.C. § 2000e-2(a)(1). Employers are required to reasonably accommodate an employee’s religion unless doing so would constitute an undue hardship (*e.g.*, “more than a de minimis cost” to the employer). 42 U.S.C. § 2000(e)(j); *Opuku-Boateng v. State of Cal.*, 95 F.3d 1461, 1467-1468 (9th Cir. 1996). But the Rule now creates a carve out from Title VII for religious *and* conscience objections in the

²³ As in other industries, religious accommodations in healthcare have been examined under Title VII. *Stormans Inc. v. Selecky*, 844 F. Supp. 2d 1172, 1201 (W.D. Wash. 2012) (challenge to state law requiring pharmacies and pharmacists to dispense lawfully prescribed emergency contraceptives over their sincere religious belief); *Shelton v. Univ. of Med. & Dentistry of N.J.*, 223 F.3d 220, 227 (3d Cir. 2000) (state hospital’s offer to transfer nurse was reasonable accommodation for her religious beliefs which prevented her from assisting in emergency pregnancy termination procedures) *Knight v. Conn. Dep’t of Health*, 275 F.3d 156 (2nd Cir. 2001) (nurse consultant’s Title VII’s rights were not violated by prohibition against proselytizing); *Grant v. Fairview Hosp. & Healthcare Servs.*, 2004 WL 326694 (D. Minn. Feb. 18, 2004) (ultrasound technician offered a reasonable accommodation when hospital excused him from performing ultrasounds on women considering abortions; hospital did not have to permit him to provide religious counseling, as that accommodation would pose an undue hardship); *Mereigh v. N.Y. & Presbyterian Hosp.*, 2017 WL 5195236 (S.D. N.Y. Nov. 9, 2017) (hospital provided reasonable accommodation to nurse objecting to family planning services); *Noesen v. Med. Staffing Network*, 232 Fed.Appx. 581 (7th Cir. 2007) (no requirement under Title VII to shift pharmacist out of all initial customer contacts to avoid him speaking to customers seeking contraception); *Bruff v. N. Miss. Health Servs., Inc.*, 244 F.3d 495, 500 (5th Cir. 2001) (no duty to capitulate to an “inflexible position” of EAP counselor who wanted to refer all LGBTQ issues to other practitioners).

1 healthcare sector, but only for those entities, medical procedures and services regulated by the
2 Rule.

3 The Rule first creates a different hiring process for regulated entities. Under Title VII's
4 requirements for accommodation of religious beliefs, an applicant or employee is generally not
5 entitled to an accommodation that relieves them of the obligation to perform the significant or
6 core duties of the position. But under the Rule, regulated entities (and possibly sub-recipients and
7 contractors) seemingly cannot inquire in advance if the employee would have any objection to
8 performing all job functions. The Rule states that an employer "may," after hiring and no more
9 than once per calendar year (unless there is "persuasive justification"), require an employee to
10 inform the employer of conscience objections. 84 Fed. Reg. at 23263.²⁴ As a consequence,
11 employers will be put in an untenable position where they may be hiring individuals who will not
12 perform the core duties of the position. And unlike the Rule's restriction on dialogue, under Title
13 VII "courts have noted that bilateral cooperation is appropriate [and consistent with Congress's
14 goal of flexibility] in the search for an acceptable reconciliation of the needs of the employee's
15 religion and the exigencies of the employer's business." *Ansonia Bd. of Educ. v. Philbrook*, 479
16 U.S. 60, 69 (1986); *Shelton*, 223 F.3d at 227

17 The accommodation process is also changed for conscience objections. Under Title VII, "a
18 sufficient religious accommodation need not be the 'most' reasonable one (in the employee's
19 view), it need not be the one the employee suggests or prefers, and it need not be the one that
20 least burdens the employee." *Ansonia Bd. of Educ.*, 479 U.S. at 68-69. The employer satisfies
21 Title VII when it offers any reasonable accommodation. *Id.*; *Shelton*, 223 F.3d at 226; *Rodriguez*
22 *v. City of Chicago*, 156 F.3d 771 (7th Cir. 1998). Also, "courts agree that an employer is not
23 liable under Title VII when accommodating the employees' religious beliefs would require the
24 employer to violate federal or state law," or if it would result in discrimination. *Sutton v.*
25 *Providence St. Joseph Med. Ctr.*, 192 F.3d 826, 830-31 (9th Cir. 1999); *Peterson v. Hewlett*
26 *Packard Co.*, 358 F.3d 599, 607 (9th Cir. 2004).

27 ²⁴ "Persuasive justification" is not defined. Does an employer have to permit an employee to
28 refuse to do portions of their job for several weeks or months before that is sufficient "persuasive
justification" to question the employee, and how will that impact the delivery of healthcare?

1 But the Rule eliminates the undue hardship exemption, and states that there is no
2 discrimination if the employee “voluntarily accepts an effective accommodation.” 84 Fed. Reg.
3 at 23191. If there is no “effective” accommodation or the person is unwilling to accept any of the
4 options offered, the Rule is silent on what can be done with that employee. Arguably, the
5 employee cannot be fired because that would be discriminatory under the Rule. *Id.*

6 The administrative complaint process also appears to be different. HHS/OCR seems to give
7 itself authority to arbitrate Title VII claims in the healthcare context by stating that it will adopt a
8 “different approach” in resolving claims of discrimination. 84 Fed. Reg. at 23191. But EEOC
9 has enforcement authority under Title VII and utilizes the “reasonableness” standard. 42 U.S.C.
10 §§ 2000e-4, 2000e-5, 2000e-8; 42 U.S.C. § 2000(e)(j); 29 C.F.R. § 1605.2. The Rule is silent on
11 what should happen if OCR and EEOC arrive at different determinations about whether an
12 accommodation is sufficient or if EEOC applies the undue hardship exemption.

13 Due to the Rule’s discrepancies with Title VII, chaos is being created where it need not
14 exist. Employers and employees will struggle to figure out which system they are supposed to be
15 using, and if it is the conscience-objector approach, that is not fully explained. Defendants failed
16 to provide even the “minimal level of analysis” to explain how the alternative accommodation
17 process will work for affected employers and employees. *Encino Motorcars*, 136 S. Ct. at 2126.

18 **3. Defendants Failed to Meaningfully Respond to Comments** 19 **Concerning the Rule’s Impacts**

20 Defendants ignore a multitude of comments from major medical organizations, patient
21 advocacy organization, academics and experts, and individuals who raised concerns that the Rule
22 will limit access to healthcare, especially in rural areas, and to the LGBTQ community, and
23 women seeking reproductive healthcare. A rule is arbitrary and capricious if the agency “failed to
24 consider an important aspect of the problem[.]” *State Farm*, 463 U.S. at 43. An agency “must
25 respond to significant points raised during the public comment period.” *Allied Local & Reg’l*
26 *Mfrs. Caucus v. EPA*, 215 F.3d 61, 80 (D.C. Cir. 2000). An Agency must address “significant”
27 comments or those “which, if true, raise points relevant to the agency’s decision.” *City of*
28 *Portland, v. EPA*, 507 F.3d 706, 715 (D.C. Cir. 2007). Defendants failed to meet this standard.

1 **a. Defendants Concede, but Dismiss, Harm to Rural Communities**

2 A significant number of organizations and individuals commented that expanded refusals
3 would undercut access to healthcare, including in emergencies, for individuals living in rural
4 communities.²⁵ Defendants concede that “patients in rural areas are more likely than patients in
5 urban areas to suffer adverse health outcomes as a result of being denied care.” 84 Fed. Reg. at
6 23253. Nevertheless, Defendants dismiss this undisputed harm by again advancing the
7 unsupported assertion that the Rule will negate this harm by preventing providers from being
8 “driven out” of the profession and maintaining that decreased access to healthcare and some
9 procedures is better than “no healthcare at all” for rural communities. *Id.* at 23253-54. But, as
10 pointed out by the National Organization for Women, patients in rural areas may not have other
11 options for health and life preserving medical care if they are denied it under the Rule.²⁶

12 Defendants also claim that rural patients are also “more likely to agree with providers in
13 objecting to certain procedures encompassed” in the Rule. 84 Fed. Reg. at 23253. But by relying
14 on these grossly unsupported generalizations, Defendants have failed to meaningfully consider
15 the comments of patients in rural areas who have expressly confirmed that they too need, want,
16 and deserve standard medical treatment and comprehensive medical care, including women
17 seeking full reproductive healthcare and LGBTQ individuals.²⁷ Women in low-income rural
18 areas will be particularly impacted by the Rule, especially as they endeavor to access
19 contraceptive and reproductive services, including maternity care and abortion. *See Zahn Dec.*
20 ¶¶ 8-10.²⁸ A Rule that allows providers to interfere with a woman’s access to contraceptives will
21 lead to unintended pregnancies and further undue hardships for women. *Lara Dec.* ¶¶ 21-22. An

22 ²⁵ *See e.g.*, Palma Dec. Ex. N, Nat. Assoc. Councils Dev. Disabilities, at 2.; Ex. L, Physicians for
23 Reproductive Health, at 6; Ex. M, Assoc. Am. Med. Coll., at 5; Ex. G, Am. Acad. PAs, at 1; Ex.
24 O, Or. Found. for Reproductive Health, at 6; Ex. P, N.C. Justice Center, at 5-6; Ex. Q, Nat. Center
25 for Lesbian Rights; Ex. R, Anti-Defamation League, at 4; Ex. S, Justice in Aging, at 3.

26 ²⁶ Palma Dec. Ex. W; *see also* Palma Dec. Ex. AA at 14 (insurance may limit options available if
27 care is denied).

28 ²⁷ *See e.g.*, Palma Dec. Ex. Z, Family Voices; Ex. AA, individual comments.

²⁸ “Whereas a single, affluent professional might experience such a refusal as inconvenient and
seek out another physician, a young mother of three depending on public transportation might
find such a refusal to be an insurmountable barrier to medication because other options are not
realistically available to her. She thus may experience loss of control of her reproductive fate and
quality of life for herself and her children. Refusals that unduly burden the most vulnerable of
society violate the core commitment to justice in the distribution of health resources.”\

1 increase in unwanted pregnancy has larger ramifications, because “[t]he ability of women to
2 participate equally in the economic and social life of the Nation has been facilitated by their
3 ability to control their reproductive lives.” *Planned Parenthood v. Casey*, 505 U.S. 833, 856
4 (1992) (plurality op.).

5 By dismissing the serious risk of harm, or even death, that patients could suffer in rural
6 areas if providers can freely deny them care, Defendants have failed to meaningfully respond to
7 this significant issue raised by numerous commenters and conceded by Defendants, thus
8 rendering the Rule arbitrary and capricious. *Del. Dep’t of Nat. Res. & Envtl. Control*, 785 F.3d 1,
9 15 (D.C. Cir. 2015); *see also Ctr. for Biological Diversity v. U.S. Bureau of Land Mgmt.*, 698
10 F.3d 1101, 1125 (9th Cir. 2012).

11 **b. Defendants’ Dismissal of the Harm to the LGBTQ Community**
12 **Does not Withstand Scrutiny**

13 Defendants are equally dismissive of comments raising concerns that the LGBTQ
14 community will be harmed by the Rule, minimizing their concerns of being “offended,” “insulted
15 or emotionally distressed” by being denied care. 84 Fed. Reg. at 23251. Defendants again claim
16 that any potential harm will be mitigated by the unsupported assertion that the Rule will prevent
17 providers from leaving the field. *Id.* And while comments stated that some LGBTQ individuals
18 are denied care altogether due to prejudices against this community (*see supra* Section I(B)(3)(a)
19 at n.31), Defendants conclude that the “burden of not being able to receive any health care clearly
20 outweighs the burden of not being able to receive a particular treatment.” 84 Fed. Reg. 23252.
21 Summarily disregarding these comments as well as studies cited by commenters that the LGBTQ
22 community already faces discrimination and barriers to basic healthcare, Defendants conclude
23 that the data is insufficient and unreliable, with “too many confounding variables,” thus
24 preventing Defendants from arriving at a “useful estimate” to quantify this harm. *Id.* Even if that
25 were true, this Court recently held that “[t]he mere fact that the ... effect[] [of a rule] is *uncertain*
26 is no justification for *disregarding* the effect entirely.” *California*, 2019 WL 1877392, at *39,
27 *citing Pub. Citizen v. Fed. Motor Carrier Safety Admin.*, 374 F.3d 1209, 1219 (D.C. Cir. 2004)
28 (emphases in original). This Court added:

1 HHS cannot simply disregard costs that are uncertain or difficult to quantify. Its
2 “Guidelines for Regulatory Impact Analysis” set forth in detail how the agency is
3 supposed to “address[] outcomes that cannot be quantified but may have important
4 implications for decision-making.” HHS Guidelines at 47. Per the Guidelines, “[i]f
5 quantification is not possible, analysts must determine how to best provide related
6 information.” *Id.* (emphasis added); *see id.* at 47–51 (laying out various approaches
7 for incorporating non-quantified effects into regulatory impact analysis). “At
8 minimum, analysts should list significant nonquantified effects in a table and discuss
9 them qualitatively.” *Id.* at 51.

6 *California*, 2019 WL 1877392, at *39. But here, Defendants only summarily address access
7 issues for the LGBTQ community (and all other patients) by listing the non-quantified cost of
8 “seeking of alternative providers of certain objected-to medical services or procedures.” 84 Fed.
9 Reg. 23227. Defendants surmise that the impact of such denials is no different than being turned
10 away because of an inability to pay for the medical service. *Id.* at 23251. This reasoning fails for
11 many of the reasons previously outlined, not the least of which being that EMTALA bars denials
12 of care in emergencies due to an inability to pay.

13 In short, the Rule is “arbitrary” or “capricious” and therefore invalid. 5 U.S.C. § 706(2)(A).
14 Although the circumstances since the enactment of the 2011 rule are relatively unchanged,
15 Defendants have made a significant change in public policy. These changes are not supported by
16 *any* new factual developments. Because Defendants have acted arbitrarily and capriciously, the
17 Rule should be found unlawful. *See Encino Motorcars*, 136 S. Ct. at 2126.

18 **C. The Rule Violates the Spending Clause**

19 Under the Spending Clause, U.S. Const., art. I, § 8, cl. 1, Congress may not impose
20 conditions on federal funds that are (1) so coercive so as to compel (rather than merely
21 encourage) States to comply, (2) ambiguous, (3) retroactive, or (4) unrelated to the federal interest
22 in a particular program. *NFIB*, 567 U.S. at 575–82; *S. Dakota v. Dole*, 483 U.S. 203, 206–08
23 (1987). Conditioning California’s receipt of federal funds on compliance with the Rule would
24 violate all four of these limitations.

25 **1. The Rule is Unconstitutionally Coercive**

26 Like other threats to strip states of all federal Medicaid funding, the Rule is an
27 unconstitutionally coercive “a gun to the head.” *NFIB*, 567 U.S. at 581. Because “Medicaid
28 spending accounts for over 20 percent of the average State’s total budget, with federal funds

1 covering 50 to 83 percent of those costs”—and because States “have developed intricate statutory
 2 and administrative regimes” in reliance on such funding—the threatened loss of federal Medicaid
 3 funding leaves States “with no real option but to acquiesce.” *Id.* at 581–82. For this reason, the
 4 Rule violates the Spending Clause: Congress may not “penalize States that choose not to
 5 participate in [a] new program by taking away their existing Medicaid funding.” *Id.* at 585.

6 Indeed, if anything, the Rule is even more coercive than the threatened loss of Medicaid
 7 funding in *NFIB*. For one thing, the Rule threatens not only Medicaid funding, but *all* funding
 8 under a vast array of health, education, and employment programs, and not just all of California’s
 9 Medicaid. Cantwell Dec. ¶ 7; Ghaly Dec. ¶¶ 8-19; Toche Dec. ¶ 12; Cervinka Dec. ¶¶ 5-16; Price
 10 Dec. ¶¶ 14-15; Parmelee Dec. ¶¶ 5-9; Nunes Dec. ¶¶ 12-18. Additionally, the unbounded,
 11 discretionary nature of its enforcement authority, *see* 84 Fed. Reg. at 23272, which impermissibly
 12 seeks to bootstrap Weldon’s consequences to two dozen now expanded federal conscience laws,
 13 heightens the coercive effect of the Rule. And whereas the conditions that could result in a loss
 14 of funding in *NFIB* were clear (failure to expand Medicaid), here, the Rule is not so clear. Given
 15 the billions of dollars of federal funding at stake, the loss of which would decimate the delivery of
 16 public services to the country’s most populous state, the Rule constitutes “economic dragooning”
 17 rather than “relatively mild encouragement” to comply. *See NFIB*, 567 U.S. at 581–82. HHS
 18 itself appears to have previously recognized the constitutional problem that would arise if, in the
 19 name of enforcing longstanding and carefully limited federal conscience laws, the federal
 20 government asserted sweeping new authority to strip states of the funding threatened here.²⁹ The
 21 Court should do the same, and therefore should hold that the Rule is unconstitutionally coercive.

22 **2. The Rule Is Unconstitutionally Ambiguous**

23 The Rule is also unconstitutionally ambiguous. If Congress desires to condition the States’
 24 receipt of federal funds, it “must do so unambiguously.” *Pennhurst State School and Hosp. v.*
 25 *Halderman*, 451 U.S. 1, 17 (1981). “[L]egislation enacted pursuant to the spending power is
 26 much in the nature of a contract; in return for federal funds, the States agree to comply with
 27 federally imposed conditions.” *Id.* Because “[t]here can, of course, be no knowing acceptance if

28 ²⁹ Palma Dec. Ex. B, Letter from OCR Director to Complainants (June 21, 2016).

1 a State is unaware of the conditions or is unable to ascertain what is expected of it,” *id.*, courts
2 deciding whether a condition is ambiguous under the Spending Clause view statutes “from the
3 perspective of a state official who is engaged in the process of deciding whether the State should
4 accept [the] funds and the obligations that go with those funds.” *Arlington Cent. Sch. Dist. Bd. of*
5 *Educ. v. Murphy*, 548 U.S. 291, 296 (2006).

6 Under this standard, the rule is unconstitutionally ambiguous. Contrary to Defendants’
7 argument that the Rule merely “mirror[s]” existing federal law, 84 Fed. Reg. at 23222, the Rule
8 creates expansive and apparently unbounded definitions untethered from prior constructions of
9 the relevant statutes. For example, the Rule allows *any* “health care personnel” to refuse medical
10 care (or refuse to perform any action that has an “articulable connection” to furthering a
11 procedure) without providing any information about the patient’s medical condition or treatment
12 options on the basis of “ethical[] or other reasons.” 84 Fed. Reg. 23263. Given this sweeping
13 and indefinite language, the State cannot make a knowing choice as to whether it would be a
14 violation of the Rule if it takes enforcement action against medical providers or programs that
15 deny care and/or who discriminate against its most vulnerable residents.

16 Additionally, the Rule is so broadly and vaguely written that it is nearly impossible to
17 ascertain how California should communicate with its sub-recipients (such as cities and counties),
18 in order to obligate them to comply with the Rule in a manner that effectively protects
19 California’s own funding. The Rule makes California responsible for policing others’
20 compliance, including other public entities that have obtained funding. 84 Fed. Reg. at 23180
21 (“[R]ecipients are responsible for their own compliance with Federal conscience and anti-
22 discrimination laws and implementing regulations, *as well as for ensuring their sub-recipients*
23 *comply with these laws.*”) (emphasis added). Thus, the State could be found in violation of the
24 Rule if a sub-recipient is found in violation, regardless of whether the State was put on notice of
25 such violation and regardless of whether such violation was condoned by the State. The
26 Spending Clause does not allow such an outcome. For example, in the Title IX context, a federal
27 funding recipient cannot be held vicariously liable for harassment perpetrated by an individual
28 employed by that recipient if the funding recipient was not on notice of the particular harassment.

1 See *Franklin v. Gwinnett Cty. Pub. Sch.*, 503 U.S. 60, 74-75 (1992) (finding school to be
 2 vicariously liable for teacher’s harassment of student because it was on notice of teacher’s
 3 discrimination and took no action); *Smith v. Metro. Sch. Dist. Perry Twp.*, 128 F.3d 1014, 1030
 4 (7th Cir. 1997) (holding that “[t]o impute liability to a program or activity” based on one person’s
 5 actions, “even if [the government entity] acted without notice” of the person’s actions, “cannot be
 6 used to support a monetary award in a Spending Clause case”); *Rosa H. v. San Elizario Indep.*
 7 *Sch. Dist.*, 106 F.3d 648, 654 (5th Cir. 1997) (“As a statute enacted under the Spending Clause,
 8 Title IX should not generate liability unless the recipient of federal funds agreed to assume the
 9 liability.”). Terminating California’s funding based on the conduct of third parties that participate
 10 in the program, including other public entities, such as counties (Cantwell Dec. ¶ 6), as the Rule
 11 purports to do, would create such an unsure stream of funding that it would be financially
 12 paralyzing for the State.

13 “[B]road interpretations of ambiguous language” in a funding condition are fundamentally
 14 unfair and violate the Spending Clause. *Clovis Unified Sch. Dist. v. Cal. Office of Admin. Hr’g*,
 15 903 F.2d 635, 646 (9th Cir. 1990); *City & Cnty. of San Francisco v. Sessions*, No. 18-cv-05146-
 16 WHO, 2019 WL 1024404, at *14 (N.D. Cal. Mar. 4, 2019). Despite the substantial amounts of
 17 funding and critical programs at risk, the State and its agencies cannot reasonably anticipate what
 18 actions Defendants might deem a violation and strip California of its funding. The Rule’s vague
 19 and subjective standards, based on overbroad definitions without regard to statutory definitions
 20 and ill-reasoned reversals of prior policy and determinations, invite inconsistent and biased
 21 enforcement by Defendants. For this reason, too, the Rule is unconstitutional.

22 3. The Rule Places Conditions on Funding Already Accepted

23 The federal government cannot “surpris[e] participating States with post-acceptance or
 24 ‘retroactive’ conditions.” *NFIB*, 567 U.S. at 582-83. Yet the Rule, as written, does just that. In
 25 *NFIB*, the Court rejected the government’s argument that the Medicaid expansion was “properly
 26 viewed merely as a modification of the existing program because the States agreed that Congress
 27 could change the terms of Medicaid when they signed on in the first place.” *NFIB*, 567 U.S. at
 28 582–83. Although the statute expressly reserved “[t]he right to alter, amend, or repeal any

1 provision of the Social Security Act, which includes the original Medicaid provisions,” the Court
2 explained that the Medicaid expansion was a shift not merely in degree, but in kind. *Id.* at 583.
3 While the prior Medicaid Act was limited to four particular categories of persons (the disabled,
4 the blind, the elderly, and needy families with dependent children), the expansion transformed
5 Medicaid into a program to meet the healthcare needs of the entire nonelderly population with
6 income below 133 percent of the poverty level. *Id.* As such, “[a] State could hardly anticipate
7 that Congress’s reservation of the right to ‘alter’ or ‘amend’ the Medicaid program included the
8 power to transform it so dramatically.” *Id.* at 584.

9 Congress conferred no authority to Defendants to “alter, amend, or repeal” the federal
10 conscience laws. Nevertheless, Defendants seek to override the existing federal conscience
11 protection framework to broadly expand not only those who are covered under federal conscience
12 protections, but also what activities are considered protected and how they are enforced. For
13 example, the Weldon, Church, and Coats-Snowe Amendments refer only to specific
14 circumstances in which healthcare providers or certain enumerated healthcare entities may not be
15 required to participate in abortions, sterilizations, or certain health service programs and research
16 activities. Nevertheless, the Rule seeks to broadly expand the scope of the circumstances under
17 which the federal conscience laws may be implicated, which constitutes a transformation in kind,
18 not degree.

19 Moreover, Defendants’ reversal of their interpretation of the Weldon Amendment as it
20 relates to California’s abortion coverage requirement constitutes retroactive, post-acceptance
21 conditions. This unsupported reversal creates uncertainties as to what additional state laws and
22 policies may also now be deemed a violation of the Rule. And the January 18, 2019 “Notice of
23 Violation” issued against California, although it concluded that further remedial action against
24 California was not warranted, could, under the Rule, be deemed a “determination” that could
25 “inform funding decision-making.” 84 Fed. Reg. at 23177, 23262.

26 California state agencies accept and plan for the receipt of federal funding with the
27 expectation that they will receive the funds under existing agreements and under existing federal
28 programs and conditions. Ghaly Dec. ¶¶ 9-10; Sturges Dec. ¶¶ 6-7; Price Dec. ¶ 16; Parmelee

1 Dec. ¶ 7; Nunes Dec. ¶ 11. State programs and local programs that depend on pass-through
 2 funding would be crippled by being unable to expend anticipated funds because they cannot
 3 absorb such a loss of funding without a reduction in staffing, programs, and services. Ghaly Dec.
 4 ¶ 8; Sturges Dec. ¶ 5; Ghaly Dec. ¶ 8, 16; Price Dec. ¶¶ 14-15; Parmelee Dec. ¶ 9; Nunes Dec. ¶
 5 10; Cervinka Dec. ¶¶ 8, 11, 13, 15; Toche Dec. ¶ 12. Thus, a sudden disruption in anticipated
 6 federal funds would create budgetary and operational chaos for state agencies providing critical
 7 services for Californians. Ghaly Dec. ¶¶ 8, 10, 12, 14, 15, 17, 18; Sturges Dec. ¶ 6; Nunes Dec. ¶
 8 10, Cervinka Dec. ¶ 16. Notably, DMHC, which administers California’s Medicaid program,
 9 known as Medi-Cal, and other federally funded healthcare programs, will receive more than \$63
 10 billion in federal funding for services and operations in Fiscal Year 2018-2019. But much of the
 11 Medi-Cal budget is expended up-front by the state in expectation of reimbursement from the
 12 federal government. Ghaly Dec. ¶ 11. The reconditioning of those existing funding will bring
 13 harm to the state’s fisc because those funds would not be reimbursed.

14 **4. The Rule Places Conditions on Funding that is Unrelated to** 15 **Protection of Conscience Objections**

16 The Spending Clause requires funding conditions “bear some relationship to the purpose of
 17 the federal spending,” *New York v. United States*, 505 U.S. 144, 167 (1992), and be “reasonably
 18 calculated” to address the “particular . . . purpose for which the funds are expended.” *Dole*, 483
 19 U.S. at 208-09. “Conditions on federal grants might be illegitimate if they are unrelated to the
 20 federal interest in particular national projects or programs.” *Id.* at 207 (quotations omitted). The
 21 Rule places various federal grants—such as those for Medicaid, HIV prevention, the prevention
 22 of child abuse and neglect, foster care placement and adoptions assistance, energy assistance for
 23 low-income, elderly and disabled individuals, among so many others—at risk even though the
 24 purposes of those statutes are wholly unrelated to the protection of conscience objections. Ghaly
 25 Dec. ¶¶ 8-9, 14-15.

26 Worse, the Rule also jeopardizes funding for California’s numerous labor and educational
 27 programs, Sturges Dec. ¶¶ 7-9; Parmelee Dec. ¶¶ 5-9—programs that lack any nexus or
 28 relationship whatsoever to the Rule’s healthcare restrictions. For example, there is no

1 “reasonable relationship” between the healthcare condition that the Rule adopts through the
2 Weldon Amendment and the operation of California’s unemployment insurance program, which
3 provides weekly payments for unemployed workers who lose their jobs through no fault of their
4 own. Sturges Dec. ¶ 8. If this Court permits OCR to condition California’s receipt of billions of
5 dollars for educational and employment programs on the State’s agreement to abide by a
6 completely unrelated federal healthcare restriction, then *Dole*’s relatedness test is rendered
7 meaningless and the federal government would be able to regulate all aspects of State government
8 through the Spending Clause.

9 **D. The Rule Violates the Establishment Clause**

10 The Rule violates the Establishment Clause because it burdens third parties, including
11 patients, employers, and employees, by purporting to guarantee an unqualified right to opt out of
12 “procedures encompassed” in the Rule in the name of a religious accommodation. 84 Fed. Reg.
13 at 23253. Government conduct may not have a primary effect that advances a particular religious
14 practice. *Catholic League for Religious & Civil Rights v. City & Cty. of S.F.*, 624 F.3d 1043,
15 1054-55 (9th Cir. 2010) (en banc). Conduct unlawfully advances religion by favoring religion at
16 the expense of the rights, beliefs, and health of others. *Corp. of Presiding Bishop of Church of*
17 *Jesus Christ of Latter-day Saints v. Amos*, 483 U.S. 327, 334-35 (1987) (“At some point,
18 accommodation may devolve into ‘an unlawful fostering of religion.’”).

19 The Supreme Court has repeatedly held that government conduct that shifts the burden to
20 accommodate religious exercise to third parties violates the Establishment Clause. The Court
21 invalidated a Connecticut statute providing employees with the absolute right to a day off on their
22 chosen Sabbath because the law “imposes on employers and employees an absolute duty to
23 conform their business practices to the particular religious practices of the employee by enforcing
24 observance of the Sabbath the employee unilaterally designates.” *Estate of Thornton v. Caldor*,
25 472 U.S. 703, 709 (1985). The Court explained that the “State thus commands that Sabbath
26 religious concerns automatically control over all secular interests at the workplace; the statute
27 takes no account of the convenience or interests of the employer or those of other employees who
28 do not observe a Sabbath.” *Id.*; *Tex. Monthly, Inc. v. Bullock*, 489 U.S. 1, 18, n.8 (1989)

1 (plurality op.) (tax-exemption for religious periodicals invalid because it substantially burdened
2 nonbeneficiaries by increasing their tax bills); *see also Cutter v. Wilkinson*, 544 U.S. 709 (2005)
3 (“courts must take adequate account of the burdens a requested accommodation may impose on
4 nonbeneficiaries”); *United States v. Lee*, 455 U.S. 252 (1982) (rejecting request for a religious
5 exemption where granting the exemption would operate to impose the employer’s faith on the
6 employee).

7 Here, the Rule permits providers, insurers, plan sponsors (i.e., employers) and other
8 healthcare personnel and entities to exempt themselves from providing a broad range of
9 healthcare services on the basis of religion, irrespective of the burden on patients, employers, and
10 other employees whose work will be impacted by the refusals. Like the law invalidated in
11 *Caldor*, the Rule delegates to individuals and private entities the ability to prefer religious
12 practice “over all secular interests,” 472 U.S. at 709, including full and equal access to healthcare
13 in accordance with ACA sections 1554 and 1557, emergency and life-saving medical care in
14 accordance with EMTALA, and consideration of the “exigencies of the employer’s business”
15 under Title VII (*Ansonia Bd. of Educ.*, 479 U.S. at 69). And unlike the 2008 rule from which the
16 Rule borrows, there is no indication that the Rule takes into account federal anti-discrimination
17 laws as an important secular concern. *See* 73 Fed. Reg. 78072. Yet the Supreme Court has held
18 that “a[] [religious] accommodation must be measured so that it does not override other
19 significant interests.” *Wilkinson*, 544 U.S. at 722.

20 The Rule is thus invalid under the Establishment Clause because it “imposes significant
21 burden[s]” on patients, employers, and employees, at the expense of a religious accommodation.
22 *Caldor*, 472 U.S. at 710; *see also Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 739 (2014)
23 (Kennedy, J., concurring) (religious accommodation must not “unduly restrict other persons, such
24 as employees, in protecting their own interests.”).

25 **II. ABSENT AN INJUNCTION, CALIFORNIA WILL SUFFER IRREPARABLE HARM**

26 The Rule will inflict immediate, irreparable harm upon California. A likely constitutional
27 violation—which is present here—is sufficient to establish irreparable harm for purposes of a
28

1 preliminary injunction. *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012). But the Rule
2 also threatens to inflict additional irreparable harm on California, as set forth below.

3 **A. Decreased Access to Healthcare and Disproportionate Impact on**
4 **Vulnerable Communities**

5 California's public health and the mission of its public health agencies will be irreparably
6 harmed by the Rule should it take immediate effect pending judicial review. *See State v. Bureau*
7 *of Land Mgmt.*, 286 F. Supp. 3d 1054, 1074 (N.D. Cal. 2018) (finding irreparable harm from
8 agency rule that "will have irreparable consequences for public health").

9 The Rule will result in decreased access to healthcare services that will disproportionately
10 harm marginalized groups in California, including individuals in rural communities, LGBTQ
11 individuals, and women. *See supra* Section I(B)(3); *see also* Aizuss Dec. ¶¶ 11-16; Palma Dec.
12 Ex. G, Am. Acad. PAs, at 1; Ex. H, Am. Nurses Assoc., at 1-2; Ex. I, Cal. Primary Care Assoc.,
13 at 1-2; Ex. AA, individual comments. For example, rural communities in California often have
14 fewer primary care doctors and specialists than may be needed to serve a given community. Lara
15 Dec. ¶ 27. Insurance coverage options are similarly limited in rural areas, often with only one or
16 two health insurers that provide coverage. Lara Dec. ¶ 27; Palma Dec. Ex. G, Am. Acad. PAs, at
17 1; Ex. AA, individual comments. Women in low-income rural areas will encounter barriers
18 trying to access contraceptive and reproductive services, including maternity care and abortion.
19 *See Zahn Dec.* ¶¶ 8-10; Lara Dec. ¶¶ 21-22. In fact, this Court recently recognized that the
20 "consequence of the reduced availability and quality of health services [including contraception]
21 is worse health outcomes for patients and the public as a whole," thus supporting preliminary
22 relief. *California*, 2019 WL 1877392 at *10.

23 Members of the LGBTQ population will also be disproportionately impacted by the Rule.
24 *See supra* Section I(B)(3)(b); Palma Dec. Ex. I, Cal. Primary Care Assoc., at 1-2; Ex. J, Cal.
25 LGBT Health & Human Serv. Network, at 2-3. The Rule can be expected to increase the number
26 of providers who will not treat someone because they are LGBTQ. Palma Dec. Ex. J, Cal. LGBT
27 Health & Human Serv. Network at 2-3. The federal government's own Office of Disease
28 Prevention and Health Promotion has acknowledged that LGBTQ persons already face health

1 disparities linked to social stigma, discrimination, and the denial of their civil and human rights
2 leading to higher rates of psychiatric disorders, substance abuse and suicide. Lara Dec. ¶ 28.
3 This Rule will limit access to mental health care for some populations, resulting in increased
4 suicide rates and treatment costs for suicide attempts. *Id.* at ¶ 29. The Rule will also limit access
5 to medical services such as HIV preexposure prophylaxis and postexposure prophylaxis, which
6 will likely result in an increase in the number of people becoming HIV positive. *Id.* at ¶ 16.

7 The Rule will decrease access to healthcare services by giving not only healthcare
8 providers, but any healthcare worker the ability to refuse medical care, or the ability to refuse
9 coverage for medically necessary services, thus making it more difficult for State entities charged
10 with overseeing Californians' access to health care to accomplish their primary missions.
11 Cantwell Dec. ¶ 8; Lara Dec. ¶ 6; *Valle del Sol Inc. v. Whiting*, 732 F.3d 1006, 1029 (9th Cir.
12 2013) (finding irreparable harm where “organizational plaintiffs have shown ongoing harms to
13 their organizational missions as a result of the statute”); *League of Women Voters of U.S. v.*
14 *Newby*, 838 F.3d 1, 9 (D.C. Cir. 2016) (holding that obstacles that “make it more difficult for the
15 [organizations] to accomplish their primary mission ... provide injury for purposes both of
16 standing and irreparable harm”).

17 **B. Consumer Confusion Resulting From Denials**

18 The Rule will result in consumer confusion about which providers will perform what
19 services and will unduly burden consumers as they try to navigate the Rule's new constraints on
20 the health care delivery system. Ghaly Dec. ¶ 19; Lara Dec. ¶ 10 (“This rule will cause confusion
21 for patients as they attempt to exercise their right to access the full range of medically appropriate
22 care, but encounter new roadblocks.”). For example, if a consumer's primary care provider
23 refuses to perform certain medically necessary services, such as sterilizations, and the provider
24 refuses to provide the enrollee with a referral to another provider, the consumer may not be aware
25 that the health plan must find another provider to perform the services. Ghaly Dec. ¶ 19; *see also*
26 *Hinze Dec.* ¶¶ 3-4. In such instances, the consumer may simply forgo the service and suffer
27 serious consequences as a result. Ghaly Dec. ¶ 19. Additionally, health plans may be unaware
28 that certain providers will refuse to perform certain services, which will add to the difficulties

1 consumers may face as they try to find providers to perform medically necessary services. *Id.*
 2 And because health plans themselves (now included as “health care entities” under the Rule) can
 3 cease covering certain medically necessary services, some patients, especially those in rural areas,
 4 may suddenly find themselves with no coverage options for care, given that some rural areas have
 5 limited health plans options. Lara Dec. ¶ 27. Those who cannot afford to travel will experience
 6 illness or even death that could have been prevented with timely access to medical care. *Id.*

7 **C. Healthcare Industry Confusion and Unworkability**

8 The Rule will cause mass confusion in the healthcare system and is unworkable. Because
 9 the Rule purports to create a broad exemption for medical professionals and personnel to opt out
 10 of healthcare services based on a moral or religious ground in a manner far beyond existing state
 11 and federal conscience laws, regulated medical providers will need to immediately consider
 12 programmatic changes to account for refusals and to ensure that patients receive medically
 13 necessary care. Price Dec. ¶¶ 8-10; Toche Dec. ¶¶ 6-8; Harris-Caldwell Dec. ¶¶ 4-5, 12-15;
 14 Parmelee Dec. ¶ 10 (Rule will necessitate changes to healthcare centers and training programs).
 15 As discussed further below, the California Department of State Hospitals (CDSH) would need to
 16 adopt a Policy Directive that would enforce its patients’ legal right to necessary medical
 17 treatment. Price Dec. ¶¶ 4-5, 8-10. California Correctional Health Care Services will also need
 18 to consider changes to ensure that inmates in the custody of CDCR receive, as they are entitled,
 19 medical, dental and mental healthcare in a nondiscriminatory and timely manner, including its
 20 transgender inmates, and female inmates in need of reproductive healthcare. Toche Dec. ¶¶ 6-8.

21 But the Rule will be unworkable if it permits a medical provider to refuse medical care
 22 without notifying a supervisor of the denial of service, or without providing notice or alternative
 23 options and/or referrals to patients. Price Dec. ¶ 10. California county public safety-net
 24 healthcare providers, including the Santa Clara Valley Medical Center³⁰ and the San Francisco
 25 Department of Public Health,³¹ also opposed the NPRM due to its confusing and unnecessary new
 26 burdens on public healthcare providers.³² And California Medical Association (CMA) noted that

27 ³⁰ Palma Dec. Ex. X, County of Santa Clara, at 2-8.

28 ³¹ Palma Dec. Ex. Y, San Francisco Dep’t. Pub. Health, at 2-3.

³² See also Palma Dec. Ex. K, Nat. Assoc. County and City Health Officials.

1 the Rule will compel California physicians to risk violating the Rule or risk violating state and
 2 federal antidiscrimination laws, as well as the ethical standards of the CMA and the American
 3 Medical Association. Aizuss Dec. ¶¶ 22-25; Pines Dec. ¶¶ 10-11.

4 Also, due to the Rule’s discrepancies with Title VII, employers and employees will struggle
 5 to figure out which system they are supposed to be using should an objection to providing
 6 medical care arise—the well-established religious accommodation process under Title VII
 7 (complete with guidance from the statute, EEOC regulations and Compliance Manual,³³ and over
 8 50 years of case law) or the Rule’s vague and contradictory process. *See supra* Section I(B)(2).

9 The Rule will also create confusion and interfere with California’s regulation of state
 10 licensed professionals. The State has laws, regulations, and efforts in place to ensure that the
 11 public health, safety and welfare by establishing minimum qualifications and levels of
 12 competency, and to provide a means for redress of grievances by investigating allegations of
 13 unprofessional conduct, incompetence, fraudulent action, or unlawful activity and, as necessary,
 14 to institute disciplinary action against licensees). Morris Dec. ¶¶ 3-4; Pines Dec. ¶¶ 3-5; Nunes
 15 Dec. ¶ 12. But the Rule will interfere with and subvert these efforts, on which Californians rely
 16 for public safety, by broadly defining “discriminate or discrimination” to include the acts of
 17 making unavailable or denying any license, certification, accreditation, title, or other similar
 18 interest for refusing to perform a service protected under the Rule. 84 Fed. Reg. at 23263.

19 **D. Public Harms If Federal Funding to Public Programs is Terminated**

20 A loss of federal funding at stake under the Rule would have a devastating impact on
 21 Californians from all walks of life who depend on services supported by these funds. Ghaly Dec.
 22 ¶¶ 8-18; *see also supra* Section III. This “budget uncertainty,” and the steps required to mitigate
 23 it, constitutes irreparable harm. *Cty. of Santa Clara v. Trump*, 250 F. Supp. 3d 497, 537 (N.D.
 24 Cal. 2017).

25 In California, county and local partners administer the vast majority of health and human
 26 services programs, and if the Rule is invoked to withhold federal funding for these programs, it
 27 will have a devastating effect on local communities. Ghaly Dec. at ¶ 10. State programs and

28 ³³ EEOC Compliance Manual available at <https://www.eeoc.gov/laws/guidance/compliance.cfm>.

1 local programs that depend on pass-through funding would be unable to absorb such a loss of
2 funding without cutting staff and services. *Id.* ¶ 8. State and local governments would be unable
3 to make up this shortfall in funding, and the critical programs would need to be cut as a
4 consequence. *Id.*

5 Cutting off federal funding to DHCS alone would bring harm to the millions of
6 beneficiaries that rely on its programs, including women, children, the elderly, people with
7 disabilities, and working families. Cantwell Dec. ¶¶ 2, 7; Cervinka Dec. ¶¶ 5-16. DHCS
8 administers and oversees multiple federally funded health care programs, including Medicaid,
9 Children’s Health Insurance Program, and several health-related federal grants. Cantwell Dec. ¶
10 2. DHCS funds health care services for approximately 13 million members of Medi-Cal,
11 California’s Medicaid program. *Id.* In fact, about one-third of Californians receive health care
12 services through programs financed and administered by DHCS, making the department the
13 largest health care purchaser in California. *Id.*

14 Cutting off federal funding to CDPH would have a devastating impact on state public health
15 programs as well as local programs that receive money from the state. Nunes Dec. ¶¶ 10, 15.
16 Both CDPH and local health departments would be unable to absorb such a loss of funding
17 without reducing staffing, programs, and services. *Id.* For example, without pass-through
18 funding from CDPH, local health department would struggle to provide immunizations against
19 measles, polio, and other deadly diseases and to continue their work preventing, diagnosing, and
20 treating sexually transmitted diseases. Nunes Dec. ¶¶ 16-19.

21 A loss of federal funding, by CDSS would put the health and safety of California’s most
22 vulnerable populations at risk. Cervinka Dec. ¶¶ 5-15. Those harmed would be the eligible aged,
23 blind, and individuals with disabilities who depend on In-Home Supportive Services and the Deaf
24 Access program, *id.* at ¶¶ 7-8, 14-15, children who depend on the Child Welfare and Foster Care
25 Programs, *id.* at ¶¶ 9-11, and refugees and other eligible immigrants who depend on the Refugee
26 Entrant Assistance program, *id.* at ¶¶ 12-13.

27 ///

28 ///

1 The California Department of State Hospitals, which currently operates under a constrained
2 budget and has a growing patient population, would have to reduce staffing and services if federal
3 funding were withdrawn. Price Dec. ¶¶ 14-15.

4 Loss of funding California receives from the U.S. Department of Labor will hamper
5 workplace safety, stifling economic development, and harming efforts to assist unemployed
6 individuals. Sturges Dec. ¶ 5. The departments and offices California's Labor and Workforce
7 Development Agency oversees will be unable to absorb such a tremendous loss of funding
8 without a reduction in staffing, programs and services. *Id.* at ¶¶ 2, 5.

9 A withdrawal of federal funding would mean that the California Community Colleges, the
10 largest system of higher education in the nation, would have to reduce staffing, programs, and
11 services. Parmelee Dec. ¶¶ 2, 8. Moreover, the system's students who rely on CalWORKS
12 services, the Foster Care Education Program, and its Vocational Education programs, would be
13 impacted and would be less able to receive a quality education. Parmelee Dec. ¶¶ 6, 9.

14 Loss of funding for the California Department of Education from the U.S. Department of
15 Education would imperil instruction programs, including Migrant Education, California Indian
16 Education Centers, Education for Homeless Children, Federal Title I, Adult Education Programs,
17 Special Education Programs for Exceptional Children, and Vocational Education; Instructional
18 Support; and Special Programs including child care and development services, the California
19 State Preschool Program, the After School Education and Safety program and the Early Head
20 Start-Child Care Partnership. Palma Dec. Ex. A, 2018-19 Cal. Dep't. Educ. budget, at 9-12.

21 In this case, the Rule makes clear that an OCR determination of noncompliance will be
22 used to inform decisions on whether to approve, renew, or modify funding to a recipient, and the
23 Rule notes that OCR has already made a determination of noncompliance against California. 84
24 Fed. Reg. at 23177, 23262. And Defendants' reversal of its interpretation of the Weldon
25 Amendment as it relates to California's abortion health plan coverage requirement puts California
26 in an impossible position: either changing its laws to comply with the unconstitutional conditions
27 in the Rule, or refuse to comply and risk losing billions in federal funds, which is the embodiment
28 of irreparable harm. *See Am. Trucking Ass'ns, Inc. v. City of Los Angeles*, 559 F.3d 1046, 1058-

1 59 (9th Cir. 2009) (motor carriers who were forced to adhere to unconstitutional provisions or
 2 give up their businesses were likely to suffer irreparable harm); *Morales v. Trans World Airlines,*
 3 *Inc.*, 504 U.S. 374, 380-81 (1992) (referring to the injury from obeying an unconstitutional law);
 4 *City & Cty. of San Francisco v. Trump*, 897 F.3d 1225, 1244 (9th Cir. 2018) (“total loss of federal
 5 funding would be catastrophic” for California counties and “the public interest cannot be
 6 disserved by an injunction that brings clarity to parties and citizens dependent on public
 7 services”).

8 **E. Immediate Economic Harm to the State**

9 Absent injunctive relief, California will have to immediately begin implementation of the
 10 Rule to avoid the crippling and catastrophic loss of funding to California. The Rule’s assurance
 11 and certification requirements (45 C.F.R. 88.4(a)(3), (5)) obligate recipients to comply with the
 12 Rule throughout the duration of funding and as a condition of continued receipt of funds. 84 Fed.
 13 Reg. 23269. Thus, the State must take immediate action to come into compliance upon the Rule’s
 14 effective date. But the Rule’s onerous assurance and certification, as well as recordkeeping,
 15 reporting, and “voluntary” notice requirements,³⁴ will immediately impose administrative burdens
 16 and implementation costs on the State. Ghaly Dec. ¶ 7; Price Dec. ¶¶ 7, 11-13; Cantwell Dec.
 17 ¶¶ 4-6; Nunes Dec. ¶¶ 7-8; Toche Dec. ¶¶ 5, 9-11; Harris-Caldwell Dec. ¶¶ 7-11.³⁵

18 The Rule will require the State to establish costly bureaucratic structures to ensure
 19 compliance with the Rule’s expansive provisions, including compliance by any downstream sub-
 20 recipients (84 Fed. Reg. at 2318). Price Dec. ¶ 13; Toche Dec. ¶ 10. DHCS will need to develop
 21 and maintain a comprehensive system for monitoring compliance at DHCS, as well as the
 22 compliance its sub-recipients, including all Medi-Cal sub-recipients, which include independent
 23 political subdivisions, such as counties. Cantwell Dec. ¶ 6. The Rule also makes CDPH liable
 24 for the actions of third parties in a manner that is unprecedented in CDPH’s experience. Nunes
 25 Dec. ¶¶ 9, 13-15. Thus, the Rule imposes an oversight obligation that forces CDPH to expend

26 ³⁴ Although the Rule states that the notice requirement is voluntary, it also states that “OCR will
 27 consider the posting of notices as “non-dispositive” evidence of compliance. 84 Fed. Reg. at
 28 23270.

³⁵ The Rule’s burdens will also be felt by physicians who will be required to divert time and focus
 from actual care to patients. Aizuss Dec. ¶¶ 30-35.

1 funds for additional staff time to monitor the compliance of its sub-recipients. *Id.* And the
2 Community Colleges estimate oversight costs of \$7,200,000 annually. Harris-Caldwell Dec. ¶ 9.

3 Moreover, because the Rule will permit providers to decline to offer services within their
4 scope of practice based on an asserted moral or religious objection, CDI will need to revamp its
5 regulation and analytics software to ensure network adequacy for California consumers. Hinze
6 Dec. ¶¶ 5-7. Network adequacy refers to a health plan's ability to deliver benefits by providing
7 access to a sufficient number of in-network primary care and specialty physicians, as well as all
8 healthcare services included under the terms of the plan. CDI is the largest consumer protection
9 agency in California and is responsible for regulating California's insurance market, which is the
10 largest in the country. Lara Dec. ¶ 4. CDI implements and enforces consumer protection laws
11 related to health insurance, including but not limited to, essential health benefits requirements,
12 anti-discrimination protections and laws pertaining to timely access to medical care. *Id.* Federal
13 law requires that health plans participating in the ACA marketplaces meet network adequacy
14 standards. 42 U.S.C. § 300gg-1(c); 42 U.S.C. § 13031(c); 45 CFR § 156.230(a). Thus, CDI
15 would incur costs for changes necessary to ensure network adequacy under the Rule. CDI
16 estimates that it will be required to expend \$256,000 in the first year and \$29,700 every year
17 thereafter. Hinze Dec. ¶¶ 5-7.

18 The Department of State Hospitals (DSH) must provide its patients with medically
19 necessary care. Civil Rights of Institutional Persons Act, 42 USC §1997, *et seq.*; Cal. Code Regs.
20 tit. 22 § 71203(a)(2)(A). Thus, it will need to adopt a new Policy Directive that would enforce
21 the legal right of its 12,000 patients to necessary medical treatment. Price Dec. ¶¶ 4, 9. That
22 policy would state that any legally and medically required service with patient consent or a court
23 order, shall be provided by DSH staff or DSH contractors. *Id.* Adoption of this policy and legal
24 staff time will require DSH to expend \$6,000 in the first year following the Rule's effective date.
25 *Id.* at ¶ 12.

26 Other state agencies will also be harmed by this Rule as they seek to implement California
27 laws relating to nondiscrimination, including laws protecting LGBTQ individuals from
28 discrimination, and access to healthcare, including law ensuring that patients receive timely,

1 accurate, and complete information to make informed decisions about their healthcare. Kish Dec.
 2 ¶¶ 2-15; Pines Dec. ¶¶ 2-7; Cantwell Dec. ¶ 6; Morris Dec. ¶¶ 2-4, 7-9. If, as a result of the
 3 Rule’s requirements, patients file complaints against medical professionals who deny care or fail
 4 to provide them with timely, accurate, and complete information, or if there is a complaint of
 5 denial of care due to an allegation of discrimination, then California’s licensing boards will have
 6 to investigate such complaints. Pines Dec. ¶¶ 12-14; Morris Dec. ¶ 9. As the largest consumer
 7 protection agency in the state, CDI also anticipates that it will receive consumer inquiries and
 8 complaints under the Rule. Lara Dec. Dec. ¶ 10.

9 **IV. THE BALANCE OF EQUITIES AND THE PUBLIC INTEREST FAVOR ISSUING AN**
 10 **INJUNCTION TO PRESERVE THE STATUS QUO**

11 Given the “potentially dire public health and fiscal consequences” of the Rule (discussed
 12 above), *California*, 911 F.3d at 582, the public interest and the balance of the equities favor of
 13 injunctive relief. Indeed, for the reasons given above, the balance of hardships sharply favors
 14 California—which means that injunctive relief would be appropriate even if California had
 15 merely raised “serious questions going to the merits” of this litigation, *Arc of California*, 757 F.3d
 16 at 983—though of course California has done more than that.

17 And in upholding a recent preliminary injunction prohibiting other federal regulations that
 18 would have reduced access to contraception, the Ninth Circuit found that an injunction was
 19 appropriate given the “potentially dire public health and fiscal consequences” and highlighted the
 20 public interest in access to contraceptive care. *California v. Azar*, 911 F.3d 558, 582 (9th Cir.
 21 2018). A preliminary injunction is also merited here for the same reasons.

22 **III. THE COURT SHOULD POSTPONE THE EFFECTIVE DATE OF THE REGULATION**
 23 **PENDING JUDICIAL REVIEW OR ISSUE A NATIONWIDE INJUNCTION**

24 Given the equities at issue, the Court should stay the effective date of this regulation until a
 25 determination on the merits, pursuant to 5 U.S.C. § 705, or issue a preliminary injunction
 26 enjoining the regulation from taking effect. This Court cannot simply draw a line around
 27 California and impose an injunction here to ensure complete relief. In this case, the harm to the
 28 healthcare industry, consumers, and employers due to the illegal rule extends beyond state lines.

1 See e.g., Aizuss Dec. ¶¶ 30-35. There is no bar against nationwide relief in the district courts,
2 even if the case was not certified as a class action, if such broad relief is necessary to give
3 prevailing parties the relief to which they are entitled, as is the case here. See *Bresgal v. Brock*,
4 843 F.2d 1163, 1171 (9th Cir. 1987) (“Class-wide relief may be appropriate even in an individual
5 action.”); *Oregon v. Azar*, No. 6:19-CV-00317-MC, 2019 WL 1897475, at *16 (D. Or. Apr. 29,
6 2019) (granting nationwide injunction); *Washington v. Azar*, No. 1:19-CV-03040-SAB, 2019 WL
7 1868362, at *3 (E.D. Wash. Apr. 25, 2019) (granting nationwide injunction); see generally
8 *California*, 911 F.3d at 584 (nationwide relief required to address “nationwide impact”).

9 **CONCLUSION**

10 The Court should enjoin implementation of the Rule.

11 Dated: June 4, 2019

Respectfully Submitted,

12 XAVIER BECERRA
13 Attorney General of California
14 MICHAEL NEWMAN
15 Senior Assistant Attorney General
16 KATHLEEN BOERGERS
17 Supervising Deputy Attorney General

/s/ Neli N. Palma

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23 *and through Attorney General Xavier*
24 *Becerra*

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CERTIFICATE OF SERVICE

Case Name: State of California v. Alex M. Azar No. 4:19-cv-02769-HSG

I hereby certify that on June 4, 2019, I electronically filed the following documents with the Clerk of the Court by using the CM/ECF system:

CALIFORNIA'S NOTICE OF MOTION AND MOTION FOR PRELIMINARY INJUNCTION, WITH MEMORANDUM OF POINTS AND AUTHORITIES;

DECLARATION OF JAY STURGES IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF CHRISTOPHER M. ZAHN, MD IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF MARI CANTWELL IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF KEVIN KISH IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF BRUCE HINZE IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF RICARDO LARA IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF MARK GHALY IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF STIRLING PRICE IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF DR. JOSEPH MORRIS IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF FRANCES PARMELEE IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF BRANDON NUNES IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF DAVID H. AIZUSS IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF DENISE PINES IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF PETE CERVINKA IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF DIANA TOCHE IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF NELI N. PALMA IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF DR. JEANNE HARRIS-CALDWELL IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

[PROPOSED] ORDER GRANTING PLAINTIFF'S MOTION FOR A PRELIMINARY INJUNCTION

I certify that **all** participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct and that this declaration was executed on June 4, 2019, at Sacramento, California.

Ashley Harrison

Declarant

/s/ Ashley Harrison

Signature

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