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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA,

Plaintiff,

v.

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

Defendants,

4:19-cv-02769-HSG

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

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

I, DAVID H. AIZUSS, M.D., declare as follows:

1. I am currently the President of the California Medical Association (CMA) and previously served as the Chair of CMA's Board of Trustees for 3 years. CMA's Board of Trustees review, debate, and set health care policy that governs CMA's advocacy in the Legislature, regulatory agencies, and the courts.

2. The California Medical Association (CMA) is a nonprofit, incorporated professional association of more than 44,000 members throughout the State of California. For

more than 150 years, CMA has promoted the science and art of medicine, the care and well-being of patients, the protection of public health, and the betterment of the medical profession. CMA's physician members practice medicine in all specialties and settings.

3. I am a licensed physician practicing in the State of California. I have been practicing medicine for 34 years as an ophthalmologist. I currently practice in Los Angeles, California.

4. I received my undergraduate degree from Northwestern University. I received my medical degree from Northwestern University Medical School. I completed my residency at the Jules Stein Eye Institute at the University of California, Los Angeles. I am board certified in ophthalmology by the American Board of Ophthalmology.

5. I am familiar with the rule "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority" (the Rule), published in the Federal Register on May 21, 2019.

6. CMA submitted comments to the United States Department of Health and Human Services (HHS) on March 27, 2018 on the Notice of Proposed Rulemaking, published in the Federal Register on January 28, 2018, that preceded the Rule.

7. The Rule purports to "protect the rights of individuals, entities, and health care entities to refuse to perform, assist in the performance of, or undergo certain health care services or research activities to which they may object for religious, moral, ethical, or other reasons" and further states that the provisions are to be "interpreted and implemented broadly to effectuate their protective purpose."

8. In 2018, HHS received 25,912 health information privacy complaints compared to 343 complaints alleging conscience violations. This was an increase from a total of 10 complaints filed with HHS under the conscience protection laws between 2005 and 2015.

9. HHS estimates that implementation of the Rule will, on average, cost $312.3 million in year one and $125.5 million annually in years two through five.

10. By issuing the Rule and creating a new division within the Office of Civil Rights ("OCR")—the new "Conscience and Religious Freedom Division"—HHS is inappropriately

using OCR's limited resources to encourage discrimination in health care and undermine the ability of states to enforce their own conscience and anti-discrimination laws.

The Rule Will Negatively Impact Access to Care

11. The Rule expands the application of existing conscience protections laws in a way that is likely to create serious barriers to patients accessing care, particularly patients seeking comprehensive reproductive health care and end-of-life care as well as patient populations that have been most vulnerable to insidious discrimination, including lesbian, gay, bisexual, and transgender individuals.

12. The Rule would allow any "entity" involved in a patient's care—from a hospital and the hospital board of directors to individuals such as the receptionist that schedules procedures and the person preparing a room for a procedure—to use their personal beliefs to disrupt a patient's access to care.

13. The Rule's definition of "assist in the performance" greatly expands the types of services that can be refused to include "an action that has a specific, reasonable, and articulable connection to furthering a procedure or a part of a health service program or research activity undertaken by or with another person or entity." In fact, merely "making arrangements for the procedure," is included in the reach of the Rule. This means individuals such as the office scheduler, the technician charged with cleaning surgical instruments, and other medical office and hospital employees, can now assert a new right to refuse care based on their religious and moral convictions. Such an interpretation is potentially disruptive to the normal operations of a medical office or other health care facility and impedes the provision of necessary care to patients.

14. The Rule also defines "referral" or "refer" to mean providing any information, "in oral, written, or electronic form … where the purpose or reasonably foreseeable outcome of the provision of the information is to assist a person in receiving funding or financing for, training in, obtaining, or performing a particular health care service, program, activity, or procedure." This includes information related to contact information, directions, instructions, descriptions, or other information resources that could help an individual to get the health care service they need.

15. Such an expansive definition could prevent patients from getting information about the availability of comprehensive health care options in their state.

16. CMA believes that these overly broad definitions will result in denial of care and miscommunication to patients without meaningfully advancing physicians' rights of conscience.

The Rule Undermines Anti-Discrimination Protections in Healthcare

17. The Rule undercuts California laws that have been put into place to ensure that patients in the state have access to comprehensive health care. The Rule interferes with existing state laws and accreditation requirements and will create needless legal confusion for California physicians.

18. California law explicitly prohibits discrimination based on sex, sexual orientation, or gender identity, among other factors. California law provides that persons holding licenses under the provisions of the Business & Professions Code, such as physicians, are subject to disciplinary action for refusing, in whole or in part, or aiding or inciting another licensee to refuse to perform the licensed services to an "applicant" (patient) because of any characteristics under the Unruh Civil Rights Act, that is, the applicant's race, color, sex, religion, ancestry, disability, marital status, national origin, medical condition, sexual orientation, or genetic information.

19. The California Supreme Court has held that physicians' religious freedom and free speech rights do not exempt physicians from complying with the Unruh Act's prohibition against discrimination based on a person's sexual orientation.

20. California law prohibits discrimination by any person under any program that receives any financial assistance from the state. Additionally, the California Insurance Gender Nondiscrimination Act prohibits a health plan and insurer from "refusing to enter into, cancel or decline to renew or reinstate a contract because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age." Sex includes both gender identity and gender expression.

21. In addition, the Rule may conflict with policies of agencies that accredit health care institutions. For example, the Joint Commission, which accredits and certifies nearly 21,000

facilities in the U.S., has required since 2011 that the nondiscrimination policy of every accredited facility protect transgender patients.

22. The Rule will compel California physicians to risk violating the Rule or risk violating state and federal antidiscrimination laws that are in place to ensure that patient populations vulnerable to discrimination have equal access to health care and health care coverage.

CMA Policy is to Balance Patients' Rights with Physicians' Conscience Rights

23. CMA advocates for conscience protections for physicians that promote the rights of physicians to exercise their conscience while ensuring that such rights do not negatively impact patient care.

24. The Rule conflicts with policy adopted by medical professional associations including CMA and the American Medical Association which assert that physicians have an "ethical responsibility to place patients' welfare above the physicians' own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their welfare."

25. According to the policy, physicians acting or refraining from acting in accordance with their conscience cannot be at the expense of their professional obligations to patients.

Existing Laws Protect Patients' and Physicians' Rights

26. Existing federal and state laws protect the rights of physicians by allowing states to take nuanced positions on protecting the conscience rights of health care workers, particularly with regard to abortion, sterilization, and aid-in-dying. The Rule's provisions are not only redundant but will have a chilling effect on the enforcement of and passage of state laws that protect access to health care.

27. California law already properly balances the rights of physicians and their patients. California has extensive protections for health care providers that do not want to participate in abortion for moral, ethical, or religious reasons, while protecting patients who need emergency

care. While religiously affiliated hospitals can also exercise their rights under this provision, they must post a notice of their refusal policy so that patients are properly informed about the care they will receive.

28. Current California law ensures that even when a patient cannot receive the services they seek at a certain facility, the patient would at least be afforded the resources, information, and options to receive treatments at an alternative site. The Rule would now "protect" the facility's moral and ethical rights to such an extent that the patient would not even receive the information they need to receive necessary medical care.

29. The Rule would impede the ability of states to craft nuanced solutions that protect the rights of providers and patients in accordance with states' own values.

The Rule's Burden on Physicians

30. Finally, the Rule puts into place new administrative requirements, imposing a significant burden on many physicians who already face an increasing number of administrative burdens under state and federal law.

31. According the Rule, physicians must submit certifications and assurances to HHS, maintain detailed records to establish compliance, cooperate with HHS's enforcement activities, and generally ensure compliance with the new Rule. It also incentivizes physicians to post lengthy required notices on their websites and in conspicuous physical locations and inform patients and employees about the federal health care conscience rights.

32. HHS conducted an analysis of the estimated burdens for the Rule in which it looks at the implementation costs for providers. The estimate includes time for providers to familiarize themselves with the Rule and the cost to hire an attorney to review it. It includes: staff time to review the assurance and certification language and underlying laws amounting to a labor cost of $93.8 million each year for the first five years; review of policies and procedures or other actions to self-assess compliance amounting to a labor cost of $46.9 million each year for the first five years; and actions to improve compliance taken by some companies such as taking remedial action, updating policies and procedures, and implementing staffing and scheduling practices

amounting to $14.8 million for the first year and $1.5 million annually for years two through five. In addition, HHS estimates that the burden on providers will amount to $93.4 million in the first year and $14.1 million annually in years two through five in costs related to the voluntary posting and distribution of notices.

33. These costs are burdensome enough in themselves; this analysis fails to fully consider, moreover, the significant time and resources it takes to continuously implement and enforce such a Rule, cooperate with any HHS enforcement actions, as well as the numerous other administrative and regulatory burdens physicians already face and the degree to which each additional burden detracts from a physician's clinical practice.

34. Excessive administrative tasks imposed on physicians divert time and focus from providing actual care to patients and improving quality and may prevent patients from receiving timely and appropriate care.

35. CMA opposes adding additional burdens to physicians that do nothing to improve the quality of patient care and create yet more regulatory hurdles for the practice of medicine.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed on May 31, 2019 in Los Angeles, California.

David H. Aizuss, M.D.
President
California Medical Association

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA,

Plaintiff,

v.

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

Defendants,

Case No. 4:19-cv-02769-HSG

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

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

I, Pete Cervinka, declare:

1. I am a resident of the State of California. I am over the age of 18 and have personal knowledge of all the facts stated herein. If called as a witness, I could and would testify competently to the matters set forth below.

2. I am currently employed by the California Department of Social Services (CDSS) and have served CDSS for ten years. I have served as the Chief Deputy Director since 2016 and previously served as the Program Deputy Director for Benefits and Services beginning in 2009.

3. CDSS is one of twelve departments and five offices within the California Health and Human Services Agency and is responsible for overseeing the administration of public social service benefit programs serving 6.3 million of California's most vulnerable residents. Our mission is to serve, aid, and protect needy and vulnerable children and adults in ways that strengthen and preserve families, encourage personal responsibility, and foster independence. CDSS has a total annual budget of $32.5 billion of federal, state and county funding to support its programs. Of this amount, approximately $13 billion are directed to child welfare programs and the In-Home Supportive Services Program, as described further below.

4. As Chief Deputy Director, I oversee programs including, but not limited to, child welfare, cash and food assistance, housing and civil rights, and Medicaid home- and community-based care. My responsibilities include policy development, program implementation and oversight, federal compliance, and associated fiscal and budgetary matters.

5. CDSS has identified specific programs that receive federal funding and would be subject to the requirements of the regulations set forth in the final rule, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, RIN 0945-AA10, published on May 21, 2019 by the U.S. Department of Health and Human Services (HHS) (Rule). These programs include: In-Home Supportive Services (IHSS), Refugee and Entrant Assistance, Deaf Access Program, Title IV-B (Child Welfare) and Title IV-E (Foster Care) of the Social Security Act.

6. If CDSS were determined to be non-compliant with the above-noted federal rule, the loss of federal funding, as identified for each program described below, would be significant and would put the health and safety of California's most vulnerable populations at risk.

In-Home Supportive Services

7. The IHSS program is a Medicaid benefit program that provides in-home assistance to eligible aged, blind, and individuals with disabilities as an alternative to out-of-home care and enables recipients to remain safely in their own homes. The purpose of the program is to allow vulnerable elderly and disabled Californians to avoid costly and unnecessary institutionalized care and to receive necessary services in their homes and communities. IHSS services include: paramedical services; accompaniment to medical appointments; personal care such as bowel and bladder care, bathing, and certain medical services under the direction of a physician; domestic and related services such as meal preparation, housecleaning, laundry, and grocery shopping; and protective supervision. Over 502,000 IHSS providers are employed to provide services to more than 594,000 IHSS recipients. More than 98 percent of the IHSS recipient population receives IHSS as a Medi-Cal (Medicaid) benefit, for which CDSS will receive approximately $6 billion in federal funding for Fiscal Year 2019.

8. A reduction in federal funding would place IHSS recipients at serious risk of institutionalization, resulting in both violations of their *Olmstead* rights and increased costs to the State, counties and federal government.

Child Welfare and Foster Care Programs

9. Titles IV-B and IV-E of the Social Security Act provide significant funding to California's child welfare system. The federal Foster Care Program, authorized by Title IV-E of the Social Security Act, helps to provide safe and stable out-of-home care for children who have been abused or neglected, until they are safely returned home, placed permanently with adoptive families, exit foster care to a guardianship with a relative, or age out of California's foster care system. Title IV-E funds, in conjunction with state and local funds, are used to provide monthly maintenance payments for the daily care and supervision of children in foster care; adoption

assistance payments; kinship guardianship assistance payments; administrative costs of activities necessary to implement the program; training of staff and foster care providers; recruitment of foster parents; and costs related to the design, implementation and operation of a state-wide data collection system. CDSS received approximately $2.2 billion in federal funding for administrative and assistance payments in Fiscal Year 2019.

10. Title IV-B provides funding for child welfare services that focus on the prevention of, and response to, child abuse and neglect. This funding supports services and programs which: 1) prevent the neglect, abuse, or exploitation of children [through the Child Abuse Prevention and Treatment Act program and the Community-Based Child Abuse Prevention program, for which CDSS received a combined $14.5 million for Fiscal Year 2019)]; 2) promote the safety, permanence and well-being of children in foster care and adoptive families, as well as to provide training, professional development and support to ensure a well-qualified workforce (for which CDSS received $29.2 million for Title IV-B Part I in Fiscal Year 2019); and 3) provides funding for states to operate coordinated child/family support and preservation services, and seeks to promote adoption and support services that prevent child maltreatment among at-risk families [(through the Promoting Safe and Stable Families program, for which CDSS received $33.4 million for administrative and assistance payments in Fiscal Year 2019)]. Thus, CDSS received a total of 77.1 million dollars in federal funding for these programs.

11. Losing Title IV-E and IV-B federal funding would be devastating to children and families served by California's child welfare system. Necessary services and supports would be substantially reduced or eliminated, placing children at further risk of abuse or neglect.

Refugee and Entrant Assistance

CDSS administers the Refugee Entrant Assistance program on behalf of the federal government. This program serves refugees and other eligible immigrants who do not qualify for Temporary Assistance for Needy Families, Supplemental Security Income, or Medicaid programs and meet the income and resource eligibility standards of the program. The purpose of this program is to assist refugees and other eligible immigrants, such as asylees, Cuban and Haitian

entrants, Special Immigrant Visa arrivals, and trafficking victims, to become employed and self-sufficient as quickly as possible and to integrate successfully into their receiving communities. Under the program, refugees and eligible individuals can receive refugee cash assistance and refugee medical assistance during their first eight months in the US, as well as a broad range of social services intended to help refugees obtain employment, achieve economic self-sufficiency, and further their social integration. The refugee social services programs include programs for elder care, school impact services, youth mentoring programs, employment training and English language acquisition services. Service providers offer a range of support to eligible recipients to further their social integration, including counseling focused on communication, stress management, and conflict resolution; employment case management; interpretation and translation; assistance with citizenship and naturalization; and assistance in connecting with health care providers.

13. CDSS received approximately $21.6 million from the federal Refugee Entrant Assistance Grant for Fiscal Year 2019. The loss of this federal funding would have an immediate negative impact on newly arrived refugees and other eligible individuals and their families, who receive support and services during the first eight months in the United States. These initial few months are critical to vulnerable individuals, who are experiencing cultural acclimation and learning to navigate a new society. The loss of federal funding would impact supports that include cash aid, employment, medical, and language services that provide critical pathways to self-sufficiency and prevent increased poverty for this already vulnerable population.

Deaf Access Program

14. The Deaf Access Program was created in 1980 to ensure that California's public social service programs are able to meet the communication needs of deaf and hard of hearing children, adults, and families. Meeting the communication needs of this population assists them in achieving economic independence to fully participate in mainstream society. The services

provided by the Deaf Access Program include sign language interpretation, advocacy, job development and placement, counseling, information and referral and community education.

15. CDSS received approximately $3 million for Fiscal Year 2019 and the loss of this federal funding would greatly reduce or eliminate the above-noted services barring access to public social service benefits.

CDSS Potential Budgetary Consequences

16. It is unclear, based on the regulatory language of the Rule, how OCR will interpret, implement, and enforce monetary consequences for noncompliance with the Rule and underlying conscience laws. The Rule specifies that OCR has authority to terminate federal financial assistance or other federal funds, in whole or in part. The potential total loss of federal funding for the above-described programs administered by CDSS would be approximately $8.3 billion. A sudden disruption in the receipt of these federal funds would create budgetary chaos and have damaging effect on the State of California, its citizens, and other residents within the State's borders.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed on June 3, 2019 in Sacramento, California.

Pete Cervinka
Chief Deputy Director
California Department of Social Services

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA,

Plaintiff,

v.

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

Defendants,

Case No. 4:19-cv-02769-**HSG**

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

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

I, Mark Ghaly, declare:

1. I am a resident of the State of California. I am over the age of 18 and have personal knowledge of all the facts stated herein. If called as a witness, I could and would testify competently to all the matters set forth below.

2. I am the Secretary of the California Health & Human Services Agency (CHHS). The California Health & Human Services Agency (CHHS) is the state's largest agency. The Secretary of CHHS is a member of the Governor's Cabinet. CHHS oversees twelve departments

and five offices that provide a range of health care services, social services, mental health services, alcohol and drug services, income assistance, and public health services to Californians from all walks of life. More than 33,000 people work for departments in CHHS at state headquarters in Sacramento, regional offices throughout the state, state institutions and residential facilities serving the mentally ill and people with developmental disabilities.

3. I was appointed Secretary of CHHS by Governor Newsom in April 2019. I am a Secretary in Governor Newsom's cabinet. My duties as Secretary of CHHS include supervising the CHHS departments and offices in administering and overseeing state programs for health care and social services. CHHS departments are instrumental in implementing Governor Newsom's goal of achieving universal coverage in the state and expanding access to care. In addition to my official duties, I am a licensed pediatrician, and I treat high-needs patients on a volunteer basis.

4. Before my appointment as Secretary of CHHS, I served for over a decade in various health care programmatic and policy leadership roles in county government. Most recently, since April 2018, I served as the Director for Health & Social Impact at the Los Angeles County Chief Executive Office, where I spearheaded and supported a number of health care, housing, and employment initiatives for the County. From 2011 until April 2018, I was the Deputy Director for Community Health and Integrated Programs for the Los Angeles County Department of Health Services. In that role, I directed clinical services for county correctional facilities; the Los Angeles County Whole Person Care Pilot Program; and created and developed a program for individuals facing chronic illnesses and homelessness to obtain permanent housing and appropriate treatment. Before my appointment in Los Angeles County, I served for five years in the City and County of San Francisco as the Medical Director for Southeast Health Center, a public health clinic located in the Bayview-Hunters Point community. As Medical Director, I supervised clinic operations and promoted community-based initiatives to improve population health. In 1996, I earned a Bachelor of Arts degree in Biology and Biomedical Ethics from Brown University. In 2002, I earned a Doctorate of Medicine from Harvard Medical School, as well as a Masters in Public Health from the Harvard School of Public Health. And in 2006, I completed my residency training in Pediatrics at the University of California, San Francisco.

5. CHHS oversees the Department of Aging, the Department of Child Support Services, the Department of Community Services & Development, the Department of Developmental Services, the California Emergency Medical Services Authority, the Department of Health Care Services, the Department of Managed Health Care, the Department of Public Health, the Department of Rehabilitation, the Department of Social Services, the Department of State Hospitals, the Office of Health Information Integrity, the Office of Law Enforcement Support, the Office of Statewide Health Planning and Development, the Office of Systems Integration, and the Office of the Patient Advocate.

6. I am familiar with the rule Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, RIN 0945-AA10, issued by the U.S. Department of Health and Human Services (HHS) on May 2, 2019, and published in the Federal Register on May 21, 2019 (Rule).

7. The Rule will impose an immediate cost on CHHS and the departments and offices it oversees due to its notice, assurance and certification, recordkeeping, and reporting requirements. Although the final rule indicates that the notice requirements are voluntary, the Rule also states that adherence to the notice requirements will be taken into consideration when assessing whether an agency is in compliance.

8. The Rule potentially places at risk all federal funds CHHS receives from the U.S. Department of Health and Human Services. For fiscal year 2019-2020, CHHS expects $77.6 billion in total federal funds in a total budget of $162.3 billion. Federal funds make up much of CHHS's budget, and a substantial portion of those federal funds come from appropriations subject to the Rule. Loss of this funding would have a devastating impact on California. State programs and local programs that depend on pass-through funding would be unable to absorb such a loss of funding without cutting staff and services. The state and local governments would be unable to make up this shortfall in funding, and the programs would need to be cut as a consequence.

9. Federal funding comes to the departments CHHS oversees from appropriations acts approved by Congress and signed by the president. The Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations

Act, 2019, Public Law 115-245, which was enacted September 28, 2019, makes appropriations for the following programs (among others), which provide funding to CHHS and the departments and offices it oversees:

- Title XIX of the Social Security Act, to operate and make payments for Medicaid which provides healthcare coverage for low-income adults, families and children, pregnant women, the elderly, and people with disabilities;
- The Child Support Enforcement and Family Support Programs for child support enforcement and family support programs;
- The Social Security Block Grant Program to assist states in delivering social services by helping reduce dependency, increase self-sufficiency, prevent abuse and neglect, and limit institutional care, if possible;
- The Older Americans Act of 1965 for programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities; ;
- The 21st Century Cures Act, section 1003(c), and the State Opioid Response Grants Program to assist state response to the opioid crisis;
- The Ryan White HIV/AIDS Program to provide primary medical care and essential support for people with HIV/AIDS; and
- The Rehabilitation Act of 1973 to ensure that individuals with disabilities have access to programs and activities that are funded by federal agencies and to federal employment.

10. In developing its annual budget, CHHS did so with the expectation that it would receive the federal funds to which it is entitled to under its existing agreements under the aforementioned federal programs—these funds are now being placed at risk under the Rule. A sudden disruption in anticipated federal funds would create budgetary chaos for CHHS, the departments and offices it oversees, and the many entities that receive pass-through federal funding. In California, county and local partners administer the vast majority of health and human services programs. If the Rule is invoked to withhold federal funding for these programs, it will have a devastating effect on local communities.

11. It is estimated that the Department of Health Care Services, which administers California's Medicaid program, known as Medi-Cal, and other federally funded health care programs, will receive more than $63 billion in federal funding for services and operations in Fiscal Year 2018-2019. Much of the Medi-Cal budget is expended up-front by the state in expectation of reimbursement from the federal government.

12. The loss of federal Medicaid or Children's Health Insurance Program funding in California would largely end the delivery of basic health care services to more than 13 million low income, elderly and pregnant individuals, as well as individuals with disabilities. Numerous studies have shown that not having access to coverage leads individuals to postpone or forgo needed medical treatment, including both preventive treatment as well as treatments for major acute or chronic conditions. Lack of access to timely treatment leads to increased emergency room use and hospitalizations, and a decline in health. Additionally, when uninsured individuals ultimately undergo medical treatment, as everyone eventually must, they often receive unaffordable medical bills, causing serious financial harms. These can include medical debt and bankruptcy.

13. The Department of Social Services estimates that it will receive nearly $2.5 billion in federal funding for various child welfare and refugee assistance programs and over $6 billion in federal funding for the In-Home Supportive Services program during Fiscal Year 2018-19.

14. If federal dollars are reduced or eliminated pursuant to implementation of the Rule, additional social services programs would be impacted, resulting in significant reductions or potentially termination of crucial supports and services that include, but are not limited to: programs for foster care placements and the prevention of child abuse awarded under Titles IV-E and IV-B; the Adoption Assistance Program, which provides financial and medical support to promote the adoption of children who otherwise would remain in long-term foster care; the Kinship Guardianship Program, which promotes permanency for foster children living with an approved relative caregiver; the In-Home Supportive Services Program, which provides services to the elderly and individuals with disabilities to remain safely within in community settings as

opposed to institutional placement; and the Refugee and Entrant Assistance Program, which coordinates the delivery of benefits and services to refugees and entrants in the state.

15. Approximately 218,000 households are served in California under the Low-Income Home Energy Assistance Program (LIHEAP). Of the households served, 162,000 are considered a vulnerable population such as elderly, individuals with disabilities, or households with children under five. LIHEAP is the primary source of financial assistance for the eligible low-income households in California to manage and meet their immediate home heating and/or cooling needs. LIHEAP also provides emergency assistance to help low-income households avoid the loss of home energy services and those facing life-threatening energy-related emergencies created by a natural disaster. The weatherization component of LIHEAP provides energy efficiency upgrades for low-income households, helping to reduce utility costs, while improving the health and safety of the occupants. The heating, cooling, and weatherization services LIHEAP helps to provide can mean the difference between life and death for recipients. Loss of federal funding for this program would deprive thousands vulnerable Californians of the support they need to keep their homes safe for habitation.

16. The California Department of Public Health's (CDPH) Immunization Branch receives substantial annual funding and support under the federal Health and Human Services appropriation, totaling almost $581 million annually. Approximately $537 million supports the Vaccines for Children program, an entitlement program allocated through the Centers for Medicare and Medicaid (CMS) which supplies vaccines for all children in the Medi-Cal program. About $8.7 million in direct assistance provides vaccines for uninsured and underinsured adults being immunized in local health departments and 500 federally qualified health center sites, as well as for outbreak containment. Of the remaining $35.4 million, half of this funding is CDPH support and half is provided through CDPH to all 61 local health departments around the state. If this $581 million in federal support is jeopardized or lost, the local health departments and federally qualified health clinics would be severely limited in their ability to provide immunizations to protect California communities against dangerous diseases,

and the state Medicaid program would need to make up a $537 million shortfall in vaccine funding for its pediatric members.

17. CDPH's STD Control Branch receives approximately $6.8 million in annual federal funding. This funding is critical for STD control programs, and enables CDPH to monitor STDs, provide information about STD trends to the public and policy makers, identify effective strategies to control STDs based on the groups and regions most at risk, provide expert consultation and training to front line local disease prevention staff, and leverage partnerships with health care systems and others to prevent disease. Losing this funding would increase the likelihood of further accelerating the rate of STD transmission at a time when STD rates, particularly syphilis and gonorrhea rates, are already rising in the state.

18. The Public Health Emergency Preparedness Program at CDPH coordinates preparedness and response activities for public health emergencies and supports surge capacity in health care and public health systems during emergencies. This program receives approximately $65 million in federal HHS funding annually, without which the state's emergency health care system could be unequipped to handle a public health crisis. These funds provide a whole community approach to emergency response for events ranging from communicable disease outbreaks like the current national measles outbreak to the catastrophic wildfires faced by California over the last few years. The funds provide for advanced planning and preparedness at the state and local level to handle the laboratory and epidemiology skills necessary to stop a communicable disease outbreak. The funds also provide for the safe evacuation of healthcare facilities and emergency medical transport, medical care in evacuation shelters, and the safe repopulation and return to normal operations of the medical and health infrastructure following an event.

19. In addition to the individual and public health harms that would occur if federal funding to these programs is terminated, the Rule will result in health care consumer confusion about which providers will perform what services and will unduly burden consumers as they try to navigate the health care delivery system. For example, if a consumer's primary care provider refuses to perform certain medically necessary services, such as sterilizations, and the provider

refuses to provide the enrollee with a referral to another provider, the consumer may not be aware that the health plan must find another provider to perform the services. In such instances, the consumer may simply forgo the service and suffer serious consequences as a result. Additionally, health plans may be unaware that certain providers will refuse to perform certain services, which will add to the difficulties consumers may face as they try to find providers to perform medically necessary services.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed on May 28, 2019 in Sacramento, California.

Mark Ghaly, MD, MPH
Secretary
California Health & Human Services Agency

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA, Plaintiff, v. **ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; DOES 1-100,** Defendants,	4:19-cv-02769-HSG **DECLARATION OF DR. JEANNE HARRIS-CALDWELL IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION**

I, Dr. Jeanne Harris-Caldwell, declare:

- I am the president of the Health Services Association, California Community Colleges (HSACCC) and the Dean of Wellness, Social Services, and Child Development at Saddleback College, as the Dean I oversees all operations of health services. Over the last 26 years I have held several progressive leadership and management roles in healthcare, and education in both California Community College, and private college systems.

1. Additionally, I have presented nationally on several occasions on health related topics and most recently for the American College Health Association. HSACCC is a

membership organization of CCC healthcare professionals and community partners. HSACCC's mission is to support and foster student access to quality health service programs within the California Community Colleges.

2. The California Community Colleges (CCC) are the largest system of higher education in the nation, with 2.1 million students attending 115 colleges. With a wide range of educational offerings, the colleges provide workforce training, basic courses in English and math, certificate and degree programs and preparation for transfer to four-year institutions. CCCs offer training for students who are pursuing careers as registered nurses, paramedics, emergency medical technicians, phlebotomists, and other health care professionals. Saddleback College offers more than 300 certificate or degree programs from architecture to oceanography. The colleges play a critical role in California's public education system and healthcare workforce training.

3. The CCCs are organized in 72 districts. Each district's Board of Trustees determines how to provide health services to students. A minority of districts outsource services to a third party; most districts run an on-campus health center. These health centers vary in size from a single practitioner to a team of dozens of medical professionals.

4. Currently, 90 community colleges have a health center. Health centers have the primary purpose of providing a scope of services to meet the student's physical, social, and mental health needs necessary to facilitate a successful completion of their academic goals and objectives. This is accomplished through provision of first aid, urgent care services, health assessment and treatment, psychological counseling & crisis intervention, health education, and community partnerships.

5. Many of the 90 health centers across within the CCC system offer robust health centers which include medical doctors, registered nurses, nurse practitioners, physician assistants, clinical psychologists, clinical psychiatrists and mental health therapists. These services provide primary care for many of the 2.1 million students within the CCC system.

6. I am familiar with the rule, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, RIN 0945-AA10, issued by the U.S. Department of Health and Human Services (HHS) on May 2, 2019 (Rule), and published in the Federal Register on May 21, 2019.

7. The Rule will impose an immediate cost on CCC health centers due to its notice, assurance and certification, recordkeeping, and reporting requirements.

8. The notification provision of the Rule will impose costs on CCC health centers. Although the Rule indicates that the notice provisions are now voluntary (unlike in the proposed rule), the Rule also states that adherence to the notice provisions will be taken into consideration when assessing whether an agency is in compliance. To provide notice, CCC health centers will need to: (1) post the notice in Appendix A (or similar text) at each CCC health center establishment where notices to the public and workforce are customarily posted, and thereafter continuously take steps to ensure that the notice is not altered, defaced, or covered by other materials, (2) include the notice on each of its websites, and (3) include the notice in its personnel manuals, applications, and benefits and training materials, as inclusion in these materials will be a factor in determining whether a CCC health center is in compliance. The estimated costs of compliance with these notification provisions is $1,350,000, due to the necessary changes to websites, physical postings, as well as costs associated with updates to training manuals, new employee documentation, internship materials, and updates to benefits handbooks.

9. The Rule also includes an assurance and certification requirement that should be included with all applications, reapplications, and amendments and modifications. The provision also places an obligation on CCC to take actions to come into compliance. Notably and under the compliance provision, if a sub-recipient (as defined by the Rule) is found in violation, CCC will be subject to remedial action. This Rule thus places some oversight obligation on CCC which could cost CCC $7,200,000 annually for additional staff time (1 staff member for monitoring and compliance, web page maintenance, form revisions, etc. at 78,000 per year with benefits at 90 health care centers) necessary to engage in this sub-recipient monitoring component as some of the health centers are operated by local hospitals. Outsourcing of health centers through MOU is

utilized within the CCC system in areas were resources are limited in order to provide access and care for all students within the CCC system.

10. The compliance provision also includes a recordkeeping and reporting requirement applicable to all recipients and sub-recipients which obligates CCC to include information concerning any compliance reviews or complaints to the Office of Civil Rights within the last three years as part of the application process. The costs of the record keeping and reporting requirements are reported in the above figures for compliance.

11. As with any compliance reporting, the HSACCC is additionally estimating another $ 135,000.00 annually for any periodic compliance reviews and/or investigations.

12. The Rule creates a broad exemption for medical professionals and personnel to opt out of healthcare services based on a moral or religious ground. Specifically, personnel may opt out of healthcare services involving abortion, sterilization, and euthanasia. Further, the rule appears to enable objections to providing a broad range of healthcare services, including certain vaccinations if there is an "aborted fetal tissue" connection (rubella, polio, Hepatitis A, chickenpox, small pox), contraception, gender transition/gender dysphoria (counseling, administering hormone prescriptions, etc.), tubal ligations, hysterectomies, and assisted suicide. There does not appear to be any exception provided for emergency situations under the Rule.

13. Many CCC health centers provide services such as immunization/vaccinations, HIV testing and counseling, contraception, STD/STI screening, gynecological services, and referrals for these and follow-up services where appropriate. The Rule appears to target many of these services for potential refusal which could hinder the provision of these services to students. The Rule could also hinder the provision of services to LGBTQ students, including counseling services that members of this community could seek out.

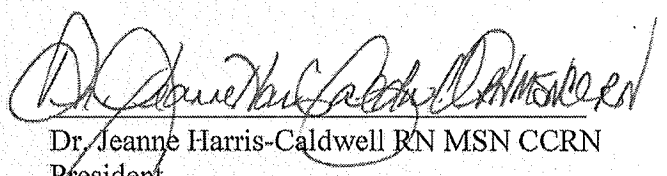
14. In addition, HSACCC is concerned that the rule will impact access or create barriers to care or services including contraception, including emergency contraception, medication abortion, family planning, etc.

15. Currently, if CCC health center staff refuse to provide a service due to a religious or moral objection, substitute staff is found to perform the objected-to service. But the Rule

expands the scope of objections that can be made to include objections on the basis of "conscience, religious beliefs, or moral convictions" to not just services such as abortion, sterilization, and euthanasia, but also "other health services." The Rule will be unworkable if it permits a medical provider to refuse "other health services" without notifying a supervisor of the denial of service, or without providing notice or alternative options and/or referrals to patients. Additionally, it would be difficult if not impossible to find a substitute provider at a health center that employs only a single health professional.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed on the 4th of June 2019 in Mission Viejo, California.



Dr. Jeanne Harris-Caldwell RN MSN CCRN
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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA,

Plaintiff,

v.

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

Defendants,

Case No.: 4:19-cv-02769-HSG

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

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

I, Bruce Hinze, declare:

1. I am an attorney in good standing licensed to practice before all courts of the State of California. I am employed in an Attorney IV classification with the California Department of Insurance ("CDI" or "the Department"), and am the senior attorney in the CDI Health Policy Approval Bureau (HPAB), which monitors health insurer legal compliance, and provide the Insurance Commissioner with legal advice regarding health insurance. My duties include estimating the anticipated workload and costs that may result from proposed legislation. If

called upon to do so, I could and would testify competently about the contents of this declaration.

2. My duties include the review and analysis of proposed federal rules relating to health coverage for their impacts on the California health insurance market. I am familiar with the final rule, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, RIN 0945-AA10, published in volume 84, number 98 of the Federal Register on May 21, 2019, beginning at page 23170.

3. In accordance with regulations promulgated by CDI, under California Code of Regulations title 10, § 2240.5, health insurers are required to annually submit reports through the System for Electronic Rate and Form Filing ("SERFF") demonstrating compliance with the network adequacy requirements of §2240.1. I was the lead attorney when the most recent revisions of these regulations were adopted in 2008, 2015, and 2016. I was also the lead in subsequent implementation of a network analytic software suite, and am the lead trainer and resource for all staff regarding network analysis.

4. The CDI network adequacy regulation requires, at California Code of Regulations title 10, § 2240.1(b)(1), that insurer networks include sufficient providers in-network to provide covered services, and, if a network provider does not provide a service that is otherwise within the scope of their practice, that the insurer must ensure there are sufficient providers within the network to provide that service.

5. The final federal rule, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority" would permit providers to decline to provide services within their scope of practice based on an asserted moral or religious objection. However, CDI's current network adequacy regulation does not require identification of objecting network providers and the objected services, nor does CDI's network adequacy analytics software provide the Department with the capability to excise objecting providers from an insurer's data set within the software suite in order to audit the adequacy of the insurers' network for services to which some providers may object to providing on conscience grounds. CDI will have to add to its network analysis procedures, in the short term, an inquiry to selected insurers regarding: (1) the number

and location of objecting providers, (2) identification of procedures not provided by these objecting providers otherwise within providers' scope of practice, and (3) identification of the network providers, if any, who provide the objected service[s] whose presence in the network backfills for the objecting providers in terms of assuring network adequacy. However, the Department will not be able to independently verify that the network is adequate. This spot inquiry will involve the expenditure of additional staff time by CDI, and by insurers. I estimate that this additional spot inquiry would involve at least 10 hours of additional time in the Attorney III category for each inquiry, analysis of insurer response, and rectification of compliance deficiencies, involving at least ten health insurers. This will represent an additional personnel cost of $11,000 per year. Insurers are charged a single fee for each network submission, and so this additional compliance review will result in no offsetting revenue to CDI.

6. In the first full calendar year after the final rule, CDI will undertake a rulemaking process to develop a revised network adequacy regulation to reflect additional insurer data submission requirements to determine adequacy of networks where providers decline to provide services within the scope of their license based on the provisions of the proposed rule. Promulgation of a revised regulation under the California Administrative Procedures Act involves at least one year of staff time in developing the proposed regulation text, soliciting public comment, and revising the text after public comments. Promulgation of such a regulation would involve approximately 1,160 hours of Attorney IV time at a cost of $157,000, as well as approximately 1,130 hours of time for staff in a variety of classifications, at a cost of $99,000, for a total personnel cost to CDI for the regulation of $256,000. Subsequent to the effective date of this regulation, review of insurer submissions would involve approximately 10 additional hours of Attorney III time per submission, involving approximately 27 annual network filings, for an additional annual personnel cost of approximately $29,700 per year.

7. I am also the Department's lead counsel in the promulgation of guidance and regulations regarding uniform provider directory standards, pursuant to California Insurance Code section 10133.15(k). The Department is already in the early phase of the rulemaking process described in that section. However, the final rule will add additional complexity to the

rulemaking regarding provider directory standards, as the Department will consider requirements regarding consumer disclosure of procedures and services not covered by a provider exercising the options described in the final rule. Consideration of these additional provider directory requirements related to the final rule will require approximately 80 additional hours of Attorney IV time during the rulemaking process, representing a cost of $10,828.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed on May 24, 2019 in San Francisco, California.

Bruce Hinze

Bruce Hinze
Attorney IV
California Department of Insurance

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA,

Plaintiff,

v.

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

Defendants,

Case No. 4:19-cv-02769-HSG

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

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

I, Kevin Kish, declare:

1. I am the Director of the California Department of Fair Employment and Housing (DFEH). I was appointed in December 2014 to lead DFEH.

2. DFEH is the state agency charged by the California Legislature with enforcing California's civil rights laws. The mission of DFEH is to protect the people of California from unlawful discrimination in employment, housing, and public accommodations and from hate violence and human trafficking. Cal. Gov't Code § 12930.

3. DFEH is responsible for enforcing state laws that make it illegal to discriminate against an employee because of certain protected categories that include religion, sex and gender (e.g. pregnancy, childbirth, breastfeeding, or related medical conditions), gender identity and gender expression, and sexual orientation, among many other bases. Among other laws, DFEH enforces the California Fair Employment and Housing Act (FEHA) (Cal. Gov't Code § 12900 et seq.), the Unruh Civil Rights Act (Cal. Civil Code § 51), and Cal. Gov't Code § 11135.

4. FEHA applies to public and private employers, labor organizations, and employment agencies. Under FEHA, it is illegal for employers of five or more employees to discriminate against employees because of a protected category, or to retaliate against them because they have asserted their rights under the law.

5. The Unruh Civil Rights Act prohibits discrimination by business establishments and is incorporated into the FEHA. Cal. Gov't Code § 12948. Unruh is violated by denying the full and equal accommodations, advantages, facilities, privileges, or services of a business establishment.

6. Under Cal. Gov't Code § 11135, no person in the State of California shall be denied full and equal access to the benefits of, or be unlawfully subjected to discrimination under, any program or activity that is conducted, operated, or administered by the state or by any state agency, is funded directly by the state, or receives any financial assistance from the state.

7. To carry out its responsibilities, DFEH facilitates a complaint process, whereby individuals who believe that they were the victim of discrimination, may file a complaint with DFEH, which is called an intake form. The submission of the intake form initiates an intake interview with a department representative to determine whether a formal complaint will be accepted for investigation. The DFEH investigator contacts the individual complainant and the investigator seeks specific facts and any records about the incident(s) and copies of any documents supporting the complaint. DFEH then evaluates the facts and decides whether the case alleges facts within DFEH's jurisdiction. DFEH does not have discretion to decline to investigate cases within its jurisdiction. If a case is within its jurisdiction, DFEH will prepare a complaint form for the individual's signature under penalty of perjury and when the individual returns the

complaint, it is delivered to the person or entity that the person believes discriminated against him/her/them, who is the respondent.

8. After a complaint is signed and issued, the respondent is required to answer the complaint. DFEH reviews the answer with the complainant. It conducts an investigation by obtaining documents and interviewing witnesses. Cases are evaluated for complexity and merit at every stage of the investigation.

9. DFEH offers free dispute resolution services to encourage parties to resolve the complaint, when appropriate. For many less complex cases, a voluntary resolution can be negotiated at any time during the complaint process. When parties cannot resolve a complaint or DFEH determines that a case is not appropriate for voluntary resolution, DFEH continues an investigation to determine if a violation of California law occurred. If it did not, the case is closed. If DFEH finds there were probable violations of the law, there is a cause finding and the case moves into DFEH's Legal Division. At that time, the parties are required to go to mediation. DFEH represents the interests of the State, and the complainant is a witness to the discrimination. At mediation, the parties have the opportunity to reach an agreement to resolve the dispute and close the case. If mediation fails, DFEH may file a lawsuit in court.

10. If an individual prefers not to use the DFEH investigation process, the individual may instead file their own lawsuit. In the context of employment discrimination, a complainant must first obtain a Right-to-Sue notice from DFEH before filing a lawsuit in court.

11. DFEH conducts an independent investigation when a complaint is filed. DFEH investigates the facts and encourages the parties to resolve the dispute in appropriate cases. DFEH considers taking legal action if evidence supports a finding of discrimination and the dispute is not resolved.

12. In addition to individual complaints, the Director may also initiate a Director's Complaint pursuant to 2 C.C.R. § 10012 on behalf of a group or class of persons adversely affected in a similar manner by an unlawful practice under FEHA.

13. I have reviewed and am familiar with the content of the final rule Protecting Statutory Conscience Rights in Health Care; Delegations of Authority that the U.S. Health and Human Services Department published on May 21, 2019 (the Rule).

14. Under state laws, DFEH has jurisdiction over complaints filed by employees alleging that their employers have not reasonably accommodated their religious beliefs or that their employers have otherwise discriminated against or harassed them on a protected basis. DFEH also has jurisdiction over complaints filed by patients, consumers, and contractors alleging that they have been denied full and equal accommodations, advantages, facilities, privileges, or services. DFEH similarly has jurisdiction over complaints of discrimination under – and unequal access to – government-funded programs and activities.

15. After considering the rule, I believe that it will impact the analysis that DFEH must engage in to carry out its required responsibilities under these laws, including analysis of the scope and application of California's own religion-based exemptions from anti-discrimination principles of general applicability, See, e.g., Cal. Gov't Code § 12926.2. It will impact the analysis that DFEH must engage in to enforce the Unruh Civil Rights Act and Cal. Gov't Code § 11135.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed on May 23, 2019 in Los Angeles, California.

Kevin Kish
Director
Department of Fair Employment and Housing

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Attorneys for Plaintiff the State of California, by and through Attorney General Xavier Becerra

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA,

Plaintiff,

v.

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

Defendants,

Case No.: 4:19-cv-02769-HSG

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

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

I, Ricardo Lara, declare:

1. I am the elected Insurance Commissioner of the State of California. I was elected to this position in November 2018 and was sworn into office on January 7, 2019. I am the first openly LGBTQ person to be elected to statewide office in California. As Insurance Commissioner, I oversee the California Department of Insurance (CDI). Prior to being elected California's Insurance Commissioner, I was elected to and served in the California State Legislature from 2010-2018.

2. I am familiar with the final Rule, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, RIN 0945-AA10, published in volume 84, number 98 of the Federal Register on May 21, 2019, beginning at page 23170.

3. If called upon to do so, I could and would testify competently about the contents of this declaration.

4. CDI is the largest consumer protection agency in the state and is responsible for regulating California's insurance market, which is the largest in the country. CDI implements and enforces consumer protection laws related to health insurance, including but not limited to, essential health benefits requirements, anti-discrimination protections and laws pertaining to timely access to medical care.

5. Based upon my knowledge and experience, I believe the Rule will harm patients by delaying timely access to medical care, result in denial of access to medically necessary health care services, and increase discrimination against patients. This Rule invites discrimination and threatens the health of Californians, particularly women, members of the lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ) community, people of color, and persons living in communities with limited medical treatment options.

6. This Rule flies in the face of decades of civil rights laws, court rulings, and our progress as a nation. This Rule allows a broad range of individuals and entities (such as medical providers, medical facilities, insurers, third-party administrators, employers, and their employees such as medical personnel, call center staff, receptionists, scheduling staff and others) to impose their personal bias against a particular medical service or patient. By giving these individuals and entities free rein to put their biases above the needs of patients, this Rule allows these individuals and entities to interfere with patient care, to refuse to provide care, or to refuse to provide health insurance coverage for medically necessary health care services. This Rule will therefore have a chilling effect on the practice of medicine, hospital operations, and insurance coverage for medically necessary services. This Rule threatens a fundamental right, the freedom from discrimination, which state and federal laws guarantee to all people.

7. The Rule interferes with enforcement of state laws that prohibit discrimination on

the basis of race, color, ancestry, marital status, sex, sexual orientation, gender, and gender identity.

8. With this Rule, the federal government threatens to withhold billions of dollars from California unless we deny Californians the privacy and anti-discrimination protections enshrined in state law and our state constitution.

9. CDI enforces laws that require that health insurers provide timely access to medical care. Health insurers submit their medical provider network data to CDI, which includes information about medical providers who are available to provide medical care to policyholders of that insurer. CDI receives consumer calls, requests for information, and complaints concerning patients who encounter difficulty receiving timely access to medical care.

10. This rule will make it more difficult for patients to access the care they need in a timely manner. When care is delayed or denied, it often results in more costly care being necessary at a later date, which can result in adverse medical outcomes. This rule will cause confusion for patients as they attempt to exercise their right to access the full range of medically appropriate care, but encounter new roadblocks. The Rule will also create confusion for health facilities, providers and insurers, given that they are bound by state laws that protect patient access to medically necessary health care, while these rules may interfere with the provision of timely access to care.

11. If providers exercise the discriminatory refusals of care invited by this Rule, insurers may find that their medical provider networks are now insufficient to provide timely access to specific necessary services. As a result, these insurers will be required to arrange for care for their policyholders with out-of-network providers. This would likely result in increased costs to the insurer that would then be passed on to policyholders. Also, given the overbroad scope of the Rule, an insurer's employee, who has no medical background or involvement in the actual treatment of the insured patient, might nonetheless object on the basis of this Rule to participating in arranging this out-of-network care, further delaying or preventing the patient from accessing care. Similarly, this Rule also increases the likelihood that a patient who goes to an in-network medical facility will be forced to see an out-of-network medical provider to get the care

they need, which in some situations will result in the patient having to pay higher, out-of-network cost-sharing.

12. Throughout my career in public service, I have heard from people who have experienced difficulty getting access to medical care because they are transgender.

13. A 2015 national transgender survey shared with CDI found that 33% of respondents who had seen a health care provider in the past year reported having at least one negative experience related to being transgender such as verbal harassment, refusal of treatment, or having to educate the medical provider about transgender people to receive appropriate care.

14. Progress has been made in terms of increasing access to needed medical care for transgender Californians. In 2012, CDI issued regulations clarifying that insurers are prohibited from denying, canceling, and limiting or refusing insurance coverage based on gender identity, expression or transgender status. Health insurance coverage in California is prohibited from arbitrarily excluding coverage for gender affirmation services including (but not limited to) hormone therapy, mental health services and surgical services. However, this Rule seeks to reverse that progress, and may embolden those who might engage in such harassment or refusal to provide care.

15. As some providers use this Rule to express their biases while practicing their profession, this Rule will increase discrimination against LGBTQ Californians. This Rule can be expected to increase the number of providers who will not treat someone because they are LGBTQ. Some pediatricians or other primary care providers may decline to treat certain patients. In some areas of California, this will make it very difficult for LGBTQ Californians to access the care they need. This type of discrimination will have devastating impacts on the health and well-being of patients, both those who are denied care and those who worry they will not be able to get care due to this Rule.

16. This Rule will limit access to medical services such as human immunodeficiency virus (HIV) preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP), which will likely result in an increase in the number of people becoming HIV positive. This Rule threatens public health. 4

17. The Federal Bureau of Investigation (FBI) reported that hate crimes have been on the rise three years in a row, but this Rule gives medical providers and others permission to discriminate against even those who need medical attention because they have just been victims of violent hate crimes.

18. The federal government should not be encouraging unlawful discrimination by adopting this regulation, which runs counter to existing state and federal privacy and anti-discrimination laws, particularly when the result will be harm to the health and well-being of already vulnerable populations.

19. Californians have a constitutionally guaranteed right to privacy. This Rule threatens the ability of Californians to exercise their right to privacy and impedes access to basic health care services.

20. As Insurance Commissioner, I enforce the Affordable Care Act (ACA) and state laws that require health insurance policies to cover preventive health care. This Rule will interfere with the ability of women to get access to and even information about the full range of reproductive health services that the law requires be covered by health insurance.

21. Prior to the passage of the ACA, CDI heard from some women who had, at times, experienced difficulty filling their prescriptions for contraceptives each month, resulting in their skipping needed pills. Some of those women became pregnant, despite having a prescription for contraceptives. A Rule that allows more pharmacists or others to interfere with a woman's access to contraceptives will result in undue hardships for women, some of whom will then face unintended pregnancies and abortions that would otherwise not have occurred.

22. This Rule will limit access to medical services for victims of sexual assault seeking treatment to prevent pregnancy. Delaying such treatment will result in unintended pregnancies. Under this Rule, we can expect that a patient who is brought to the nearest emergency room for treatment may need to later transport themselves to a different medical facility where they can receive the treatment they need. By then, it may be too late to prevent an unintended pregnancy.

23. This Rule also seeks to make it more difficult for women in many communities to

access abortion services. To the extent that a woman's access is delayed, the type of procedure that will be medically appropriate may change and the cost of that procedure will be higher than if she was able to access abortion services earlier in her pregnancy.

24. In a circumstance where sterilization is being used for preventive purposes, such as a preventive oophorectomy (removal of ovaries) to reduce the risk of future cancers for women with the high-risk BRCA genetic mutation, this Rule could make it possible for providers to delay or prevent this treatment.

25. This Rule will limit access to medical services in rural communities and other geographic areas with limited numbers of health care providers, which will endanger patients.

26. The Rule acknowledges that "…patients in rural areas are more likely than patients in urban areas to suffer adverse health outcomes as a result of being denied care" (84 Fed. Reg. at 23253) and yet astoundingly the Rule creates a situation in which an overly broad range of people and entities will have the ability to interfere with the ability of a patient who needs medical to care to receive that care.

27. Rural communities in California often have fewer primary care doctors and specialists than may be needed to serve a given community. Additionally, in some communities, an individual or employer may only have a choice of one or two health insurers in particular geographic areas when buying coverage. This Rule will be particularly harmful in areas where the small number of medical providers and/or insurers serving the area already presents challenges to timely access to medical care. Some people will have to drive long distances to access care. Others will not be able to afford to travel to receive the medical care they need, which may result in illness or even death that could have been prevented with timely access to medical care.

28. The Federal Office of Disease Prevention and Health Promotion has acknowledged that LGBTQ persons already face health disparities linked to social stigma, discrimination, and denial of their civil and human rights leading to higher rates of psychiatric disorders, substance abuse and suicide. By allowing health care providers to discriminate against LGBTQ persons, this Rule poses a direct threat to the health of LGBTQ patients.

29. This Rule will limit access to mental health care for some populations, resulting in increased suicide rates and treatment costs for suicide attempts, and substance abuse and treatment costs for substance abuse.

30. This Rule will interfere with serving the needs of a diverse community. The Rule threatens the health and safety of Californians.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed on May 24, 2019 in San Francisco, California.

Ricardo Lara
Insurance Commissioner
State of California

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA, Plaintiff, **v.** **ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; DOES 1-100,** Defendants,	4:19-cv-02769-HSG **DECLARATION OF DR. JOSEPH MORRIS IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION** 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

I, Joseph Morris, PhD, MSN, RN, declare:

1. I am the Executive Officer of the Board of Registered Nursing (Board) and an active licensed Registered Nurse in the State of California. I make this declaration in my official capacity as the Executive Officer of the Board and make this declaration of my own personal knowledge.

2. The California Board of Registered Nursing (the Board) is a state governmental agency established to protect the public by regulating the practice of registered nurses; it is

organized under the California Department of Consumer Affairs. Cal. Bus. & Prof. Code §§ 101, 2701. The Board is responsible for implementing and enforcing the Nursing Practice Act. The Board's authorizing statutes designate protection of the public as its highest priority. Cal. Bus. & Prof. Code § 2708.1.

3. To carry out its mission to protect the public, the Board performs a number of functions, including but not limited to:

- Establishing educational standards for nursing programs which prepare individuals to become licensed as registered nurses;
- Evaluating licensure applications to determine whether the applicant meets the criteria for licensure;
- Enforcing state law by taking appropriate disciplinary action against nurses who violate the Nursing Practice Act and relevant provisions of the Business & Professions Code;
- Adopting regulations to clarify the performance, practice, and disciplinary standards for its licensees.

4. The Board's Enforcement Division protects consumers from licensees who practice in a manner that may be unsafe or unprofessional. The Board has authority to revoke, suspend, or place on probation any license if the licensee has violated a provision of the law governing the profession. Cal. Bus. & Prof. Code § 2759.

5. I am familiar with the rule Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, RIN 0945-AA10, issued by the U.S. Department of Health and Human Services (HHS) on May 2, 2019, and published in the Federal Register on May 21, 2019 (the Rule).

6. The Rule creates a broad exemption for medical professionals and personnel to opt out of any healthcare service based on a moral or religious ground. Specific scenarios are included in the Rule, including abortion, sterilization, euthanasia, certain vaccinations if there is an "aborted fetal tissue" connection (rubella, polio, Hep A, chickenpox, small pox), contraception, gender transition/gender dysphoria (counseling, administering hormone

prescriptions, etc.), tubal ligations, hysterectomies, assisted suicide, and referrals for advanced directives, and there does not appear to be any exception provided for emergency situations.

7. Under the Rule, nurses can refuse medical care without any information about the patient's medical condition or treatment options, not just on the basis of federally protected conscience protections, but also on the basis of "ethical or other reasons." A provider can do this without any supporting evidence, without notifying a supervisor of the denial of service, and without providing notice or alternative options and/or referrals to patients in need

8. The Rule if implemented may thus impact the work and mission of the Board.

9. If, as a result of the Rule's requirements, patients file complaints against nurses who deny care or fail to provide them with timely, accurate, and complete information, then the Board will have to investigate such complaints.

10. Furthermore, the Board is responsible for enforcing California law through disciplinary proceedings. Thus, the Board may face an increase in disciplinary matters for nurses that fail to abide by the Nursing Practice Act, including standards of care.

11. Notably, the standards of competent performance that nurses must abide by include acting as the patient's advocate which includes giving the patient the opportunity to make informed decisions about healthcare. Cal. Code Regs. tit. 16, § 1443.5(6) (2019). Failing to act in an emergency thereby jeopardizing a patient's health or life could also result in a charge of "gross negligence." Cal. Code Regs. tit. 16, § 1442.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed on May 29, 2019 in Sacramento, California.

Dr. Joseph Morris
Executive Officer
California Board of Registered Nursing

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA,

Plaintiff,

v.

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

Defendants,

Case No. 4:19-CV-02769-HSG

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

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

I, Brandon Nunes, declare:

1. I am a resident of the State of California. I am over the age of 18 and have personal knowledge of all the facts stated herein. If called as a witness, I could and would testify competently to all the matters set forth below.

2. I am the Chief Deputy Director of Operations for the California Department of Public Health (CDPH). CDPH has nearly 3,800 employees working in over 200 program areas to serve the people of California.

3. I was appointed Chief Deputy Director of Operations in May 2015. In this capacity, and as a member of the CDPH directorate, I have responsibility in overseeing and supporting our department's programs to ensure they have the resources they need to successfully implement their mission and the mission of CDPH.

4. Prior to my appointment as Chief Deputy Director of Operations, I worked for over 16 years at the California Department of Finance (DOF) in various roles. The first eight years of my time with DOF was spent in the Office of State Audits and Evaluations (OSAE). OSAE is responsible for all Executive Branch audit functions, including financial audits, performance audits, and compliance audits. During my time at OSAE, I lead and supervised a number of audit teams responsible for evaluating and advising on the programmatic, administrative, and fiscal policies of a wide variety of state and local entities. The second half of my career with DOF was spent in the Health and Human Services Budget Unit. During this time, I was responsible for developing, overseeing, and defending the budgets of a number of departments under the California Health and Human Services Agency, including the Department of Public Health and the Department of Social Services.

5. CDPH works to optimize and protect the health and wellbeing of the people in California. Our fundamental responsibilities include infectious disease control and prevention, food safety, environmental health, laboratory services, patient safety, emergency preparedness, chronic disease prevention and health promotion, family health, health equity, and vital records and statistics. Our key activities include protecting people in California from the threat of preventable infectious diseases like Zika virus, HIV/AIDS, tuberculosis, and viral hepatitis, and providing reliable and accurate public health laboratory services and information about health threats. CDPH also protects patient safety in hospitals and skilled nursing facilities, maintains birth and death certificates, and prepares for and responds to public health emergencies. CDPH works continuously to reduce health and mental health disparities affecting vulnerable and underserved communities to achieve health equity throughout California. Indeed, CDPH programs and services touch the lives of every Californian and visitor to the state 24 hours a day, seven days a week.

6. I am familiar with the rule, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, RIN 0945-AA10, issued by the U.S. Department of Health and Human Services (HHS) on May 2, 2019 (Rule), and published in the Federal Register on May 21, 2019.

7. The Rule has already imposed costs on California. CDPH has spent more than 30 hours of program staff and attorney time reading and analyzing the Rule in order to determine its potential impacts on our programs, workforce, and partnerships with local health departments.

8. The Rule will impose immediate costs on CDPH. Although the final rule indicates that notice requirements are now voluntary, the Rule also states that adherence to the notice requirements will be taken into consideration when assessing whether an agency is in compliance. In accordance with section 88.5 of the Rule, CDPH will incur costs developing easy-to-understand, accessible materials for CDPH staff and others, including written policies and procedures, electronic notices, and updates to CDPH's internal and external websites. CDPH will also incur costs creating and operationalizing new training modules.

9. Currently, CDPH has nearly 670 contracts that involve federal funding. These contracts help fund public health efforts throughout the state. For fiscal year 2018-2019, CDPH's budget was approximately $3.2 billion, which included approximately $1.5 billion from the federal government.

10. The Rule jeopardizes all federal funds CDPH receives from the U.S. Department of Health and Human Services, including the Centers for Disease Control and Prevention, as well as from the U.S. Department of Education and the U.S. Department of Labor. Loss of this federal funding will have a devastating impact on California, the nation's most populous state, both by impacting state public health programs and by having a cascading impact on local health departments dependent on federal funding that flows through the state. CDPH—and, in all likelihood, the local health departments—will be unable to absorb such a tremendous loss of funding without a reduction in staffing, programs, and services.

11. In developing its annual budget, CDPH did so with the expectation that it would receive the federal funds to which it is entitled to under its existing agreements with the aforementioned federal agencies—these funds are now being placed at risk under the Rule. A

sudden disruption in anticipated federal funds would create budgetary chaos for both state and local public health programs and undermine their ability to deliver vital public health programs and services.

12. Federal funding supports numerous programs within CDPH, including through dollars that support state operations or are passed through to local health departments. With regard to CDPH's 2018-2019 budget, the Rule jeopardizes the following public health programs, and corresponding federal funding dollars (among others):

- Public Health Emergency Preparedness Program, which coordinates preparedness and response activities for all public health emergencies, including natural disasters, acts of terrorism, and pandemic diseases and plans and supports surge capacity in the medical care and public health systems to meet needs during emergencies ($31.4 million for state operations and $59.1 million for local assistance in 2018-2019);
- Chronic Disease Prevention and Health Promotion, which works to prevent and control chronic diseases, injuries, and violence, including reducing the prevalence of obesity, reducing and preventing tobacco use, promoting safe and healthy environments, and treating problem gambling ($23.7 million for state operations and $12.2 million for local assistance in 2018-2019);
- Infectious Diseases Program, which works to prevent and control infectious diseases such as: HIV/AIDS, viral hepatitis, influenza and other vaccine-preventable illnesses, sexually transmitted diseases, tuberculosis, emerging infections, and foodborne illnesses ($66.0 million for state operations and $215.6 million for local assistance in 2018-2019);
- Health Statistics and Informatics Program, which develops data systems and facilitates the collection, validation, analysis, and dissemination of health information ($913,000 for state operations in 2018-2019);
- County Health Services Program, which supports county-based public health information and services ($3.9 million for local assistance in 2018-2019);

- Programs within the Center for Environmental Health, which work to protect and improve the health of all California residents by providing for the safety of food, drugs, and medical devices; conducting underage tobacco enforcement; conduct environmental management programs; and oversee the use of radiation through investigation, inspection, laboratory testing, and regulatory activities ($1.4 million for state operations in 2018-2019);
- Health Facilities Licensing Program, which regulates the quality of care in over 10,000 public and private health facilities, clinics, and agencies throughout the state; licenses nursing home administrators; certifies nurse assistants, home health aides, and hemodialysis technicians; and oversees the prevention, surveillance, and reporting of healthcare-associated infections in California's general acute care hospitals ($102.1 million for state operations in 2018-2019); and
- Laboratory Field Services Program, which regulates quality standards in approximately 22,000 clinical laboratories, public health laboratories, blood banks, and tissue banks in California; and licenses approximately 60,000 scientific classifications that include 30 different categories of laboratory personnel including laboratory scientists, phlebotomists, genetic scientists, clinical chemists, and public health microbiologists ($1.7 million for state operations in 2018-2019).

13. The Rule makes CDPH liable for the actions of third parties in a manner that is unprecedented in CDPH's experience and unworkable in practice. This is because the Rule dictates that if a sub-recipient violates the Rule, the sub-recipient's violation jeopardizes CDPH's funding as a recipient. Specifically, the Rule includes an assurance and certification requirement that should be included with all applications, reapplications, and amendments and modifications. The provision also places an obligation on CDPH to take actions to come into compliance. But if a sub-recipient (as defined by the Rule) is found in violation, CDPH will be subject to remedial action, including the loss of some or all of the federal funding described above.

14. By making CDPH responsible for the compliance of sub-recipients, the Rule appears to impose an oversight obligation that requires CDPH to expend funds for additional staff

time to monitor the compliance of sub-recipients. Even if monitoring is not required under the Rule, the Rule is so broadly and vaguely written that it is nearly impossible to ascertain how CDPH should communicate with its sub-recipients, including through the re-drafting of its contracts, in order to obligate its sub-recipients to comply with the Rule in a manner that effectively protects CDPH's own federal funding.

15. Terminating CDPH's funding based on the conduct of third parties that CDPH neither controls nor operates would hobble the state's ability to protect the public health. For example, federal funding for CDPH and for all counties could be placed at risk based on the alleged violation of a single county, a separate legal entity from the state (Cal. Gov. Code § 23000, et seq.).

16. As one example, CDPH's Immunization Branch receives substantial annual funding and support under the federal Health and Human Services appropriation, totaling almost $581 million annually. Approximately $537 million supports routine childhood vaccines, $8.7 million covers routine vaccines for uninsured and underinsured adults, and $35.4 million provides financial assistance for state and local operations each year. Of this $35.4 million in operations funding, approximately half ($17 million) is provided to 61 local health departments throughout California. Under the Rule, even if CDPH contractually obligates all local health departments to comply with the Rule, and a single violation is committed without CDPH's knowledge, this violation would put CDPH's funding and pass-through funding at risk. And, as a result of the loss of federal funding, local health departments would struggle to provide immunizations against deadly diseases such as measles, polio, and tetanus.

17. As another example, CDPH's Sexually Transmitted Diseases (STD) Control Branch provides support, guidance, coordination and safety-net services to local STD control programs. CDPH receives $6.8 million in federal funding, including $1.5 million that is passed through to local STD control programs throughout California. Under the Rule, even if CDPH contractually obligates all local health departments to comply with the Rule, and a single violation is committed without CDPH's knowledge, this violation would put CDPH's funding at risk. STD rates are currently on the rise in California: In 2017 compared to 2016, the rate of

syphilis increased 9%, the rate of gonorrhea increased 16%, and the rate of early syphilis increased 21%. If CDPH lost federal funding due to one local health department's non-compliance with the Rule, many local health departments could struggle to continue their work preventing, diagnosing, and treating STDs.

18. In addition to the potential decimation of public health programs in the state due to the potential loss of federal funding, CDPH is also concerned that the Rule's position on vaccinations, and its potential to encourage doctors opposed to the state's efforts to ensure that all families follow the recommended childhood vaccination schedule, will adversely affect California's public health efforts to control the spread of preventable diseases such as measles.

19. As of April 24, 2019, 38 confirmed measles cases, including 28 outbreak-associated cases, have been reported in California. The outbreak of measles has an impact beyond state lines. The last large outbreak of measles in California was associated with Disneyland and occurred from December 2014 to April 2015, when at least 131 California residents were infected with measles, and also infected residents of six other states, Mexico, and Canada.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed on May 31, 2019, in Sacramento, California.

Brandon Nunes
Chief Deputy Director of Operations
California Department of Public Health