UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.; and PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, INC., Plaintiffs, v. ALEX M. AZAR II, in his official capacity as Secretary, United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROGER SEVERINO, in his official capacity as Director, Office for Civil Rights, United States Department of Health and Human Services; and OFFICE FOR CIVIL RIGHTS, United States Department of Health and Human Services, Defendants.	Civil Action No. 1:19-cv-5433 (PAE) (rel. 1:19-cv-4676; 1:19-cv-5435)
NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION; and PUBLIC HEALTH SOLUTIONS, Plaintiffs, v. ALEX M. AZAR II, in his official capacity as Secretary of the U.S. Department of Health and Human Services; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROGER SEVERINO, in his official capacity as Director of the Office for Civil Rights of the U.S. Department of Health and Human Services; OFFICE FOR CIVIL RIGHTS of the U.S. Department of Health and Human Services, Defendants.	Civil Action No. 1:19-cv-5435 (PAE) (rel. 1:19-cv-4676; 1:19-cv-5433)

DECLARATION OF SARAH MAC DOUGALL

SARAH MAC DOUGALL declares pursuant to 28 U.S.C. § 1746 as follows:

1. I am an associate at Covington & Burling LLP, and counsel to Plaintiffs Planned Parenthood Federation of America, Inc. ("PPFA") and Planned Parenthood of

Northern New England, Inc. ("PPNNE") in *PPFA et al. v. Azar et al.*, No. 1:19-cv-5433 ("PPFA Action"). This Court has accepted the PPFA Action as related to *National Family Planning and Reproductive Health Services Association et al. v. Azar et al.*, No. 1:19-cv-5435 ("NFPRHA Action"), and, on June 14, 2019, granted permission for the plaintiffs in those cases to file a joint motion for preliminary injunctive relief. *See* PPFA Action Dkt. No. 17; NFPRHA Action Dkt. No. 23.

2. I make this declaration in support of Plaintiffs' Joint Motion for Preliminary Injunction and Memorandum in Support, and to place before the Court documents and information necessary for the determination of the Motion.

3. Attached as Exhibit A is a true and correct copy of select federal statutory provisions, attached for the Court's convenience.

4. Attached as Exhibit B is a true and correct copy of the declaration of Kimberly Custer, Executive Vice President, Health Care Division, PPFA, dated June 14, 2019.

5. Attached as Exhibit C is a true and correct copy of the declaration of Meagan Gallagher, President and CEO, PPNNE, dated June 13, 2019.

6. Attached as Exhibit D is a true and correct copy of the declaration of Clare M. Coleman, President and CEO, National Family Planning & Reproductive Health Association, dated June 17, 2019.

7. Attached as Exhibit E is a true and correct copy of the declaration of Lisa David, President and CEO, Public Health Solutions, dated June 17, 2019.

8. Attached as Exhibit F is a true and correct copy of the declaration of Stephen Todd Chasen, M.D., F.A.C.O.G., Professor of Clinical Obstetrics and Gynecology at Weill Cornell Medical College, Cornell University, and Attending Obstetrician and Gynecologist at New York Presbyterian Hospital, dated June 13, 2019.

I declare under penalty of perjury that the information above is true and correct.

Executed on June 17, 2019, in New York, New York.

/s/ Sarah Mac Dougall

EXHIBIT A

Church Amendments, 42 U.S.C. § 300a-7

(a) Omitted

(b) Prohibition of public officials and public authorities from imposition of certain requirements contrary to religious beliefs or moral convictions

The receipt of any grant, contract, loan, or loan guarantee under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Services and Facilities Construction Act by any individual or entity does not authorize any court or any public official or other public authority to require—

> (1) such individual to perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions; or
>
> (2) such entity to—
>
> > (A) make its facilities available for the performance of any sterilization procedure or abortion if the performance of such procedure or abortion in such facilities is prohibited by the entity on the basis of religious beliefs or moral convictions, or
> >
> > (B) provide any personnel for the performance or assistance in the performance of any sterilization procedure or abortion if the performance or assistance in the performance of such procedures or abortion by such personnel would be contrary to the religious beliefs or moral convictions of such personnel.

(c) Discrimination prohibition

> (1) No entity which receives a grant, contract, loan, or loan guarantee under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Services and Facilities Construction Act after June 18, 1973, may—
>
> > (A) discriminate in the employment, promotion, or termination of employment of any physician or other health care personnel, or
> >
> > (B) discriminate in the extension of staff or other privileges to any physician or other health care personnel,
>
> because he performed or assisted in the performance of a lawful sterilization procedure or abortion, because he refused to perform or assist in the performance of such a procedure or abortion on the grounds that his performance or assistance in the performance of the procedure or abortion would be contrary to his religious beliefs or moral convictions, or because of his religious beliefs or moral convictions respecting sterilization procedures or abortions.

(2) No entity which receives after July 12, 1974, a grant or contract for biomedical or behavioral research under any program administered by the Secretary of Health and Human Services may—

(A) discriminate in the employment, promotion, or termination of employment of any physician or other health care personnel, or

(B) discriminate in the extension of staff or other privileges to any physician or other health care personnel,

because he performed or assisted in the performance of any lawful health service or research activity, because he refused to perform or assist in the performance of any such service or activity on the grounds that his performance or assistance in the performance of such service or activity would be contrary to his religious beliefs or moral convictions, or because of his religious beliefs or moral convictions respecting any such service or activity.

(d) Individual rights respecting certain requirements contrary to religious beliefs or moral convictions

No individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions.

(e) Prohibition on entities receiving Federal grant, etc., from discriminating against applicants for training or study because of refusal of applicant to participate on religious or moral grounds

No entity which receives, after September 29, 1979, any grant, contract, loan, loan guarantee, or interest subsidy under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Assistance and Bill of Rights Act of 2000 may deny admission or otherwise discriminate against any applicant (including applicants for internships and residencies) for training or study because of the applicant's reluctance, or willingness, to counsel, suggest, recommend, assist, or in any way participate in the performance of abortions or sterilizations contrary to or consistent with the applicant's religious beliefs or moral convictions.

Coats-Snowe Amendment, 42 U.S.C. § 238n

(a) In general

The Federal Government, and any State or local government that receives Federal financial assistance, may not subject any health care entity to discrimination on the basis that—

> (1) the entity refuses to undergo training in the performance of induced abortions, to require or provide such training, to perform such abortions, or to provide referrals for such training or such abortions;
>
> (2) the entity refuses to make arrangements for any of the activities specified in paragraph (1); or
>
> (3) the entity attends (or attended) a post-graduate physician training program, or any other program of training in the health professions, that does not (or did not) perform induced abortions or require, provide or refer for training in the performance of induced abortions, or make arrangements for the provision of such training.

(b) Accreditation of postgraduate physician training programs

> (1) In general
>
> In determining whether to grant a legal status to a health care entity (including a license or certificate), or to provide such entity with financial assistance, services or other benefits, the Federal Government, or any State or local government that receives Federal financial assistance, shall deem accredited any postgraduate physician training program that would be accredited but for the accrediting agency's reliance upon an accreditation standards1 that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether such standard provides exceptions or exemptions. The government involved shall formulate such regulations or other mechanisms, or enter into such agreements with accrediting agencies, as are necessary to comply with this subsection.
>
> (2) Rules of construction
>
> > (A) In general
> >
> > With respect to subclauses (I) and (II) of section 292d(a)(2)(B)(i) of this title (relating to a program of insured loans for training in the health professions), the requirements in such subclauses regarding accredited internship or residency programs are subject to paragraph (1) of this subsection.

(B) Exceptions

This section shall not—

(i) prevent any health care entity from voluntarily electing to be trained, to train, or to arrange for training in the performance of, to perform, or to make referrals for induced abortions; or

(ii) prevent an accrediting agency or a Federal, State or local government from establishing standards of medical competency applicable only to those individuals who have voluntarily elected to perform abortions.

(c) Definitions

For purposes of this section:

(1) The term "financial assistance", with respect to a government program, includes governmental payments provided as reimbursement for carrying out health-related activities.

(2) The term "health care entity" includes an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions.

(3) The term "postgraduate physician training program" includes a residency training program.

Weldon Amendment[1]

(d)(1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(2) In this subsection, the term "health care entity" includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

[1] *E.g.*, Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2019, Div. B, § 507(d), Pub. L. No. 115-245, 132 Stat. 2981, 3118 (Sept. 28, 2018).

EXHIBIT B

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., and PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, INC., Plaintiffs, v. ALEX M. AZAR II, Secretary of the United States Department of Health and Human Services, in his official capacity, *et al.*, Defendants.	Civil Action No. 1:19–cv–05433 Hon. Paul A. Engelmayer

DECLARATION OF KIMBERLY CUSTER
IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Kimberly Custer, declare and state as follows:

1. I am the Executive Vice President of the Health Care Division for Planned Parenthood Federation of America, Inc. ("PPFA").

2. This declaration is based on the knowledge and experience I have acquired in two decades of employment with PPFA and several PPFA member-affiliates, a review of PPFA business records, and information obtained through the course of my duties at PPFA. If called and sworn as a witness, I could and would testify competently thereto.

3. I submit this declaration in support of Plaintiffs' Motion for a Preliminary Injunction, which seeks to prevent the enforcement of the rule entitled "Protecting Statutory Conscience Rights in Health Care," 84 Fed. Reg. 23,170 (May 21, 2019) (to be codified at 45 C.F.R. pt. 88) (the "Refusal of Care Rule" or the "Rule"). I am familiar with the Refusal of Care Rule.

4. As I understand it, the Refusal of Care Rule could force PPFA and its member-affiliates to accommodate a broad group of individuals, including employees, interns, volunteers, trainees, and contractors, who—contrary to our mission—refuse to provide or assist with core reproductive services, such as abortion, sterilization, and potentially other health services, regardless of the burden that it would impose on our health centers and their patients. I also understand that the Rule broadly defines "assisting in the performance" of a procedure or service to include, among other activities, "counseling, referral, training, or otherwise making arrangements" for the procedure or service. The accommodation required by the Rule would threaten Planned Parenthood patients' access to comprehensive reproductive health care, and run counter to our medical standards requiring that patients be provided with information and health care in an objective and nonjudgmental manner. In many cases absolute accommodation would also be costly and time-consuming, and result in a disruption in services. In certain circumstances, it would be impossible.

5. The accommodation required by the Rule would also pose security and privacy risks to Planned Parenthood and our patients. It is already the case that anti-abortion individuals seek positions with our affiliates in order to obtain information about Planned Parenthood and our patients. The Rule will severely hamper the ability of our affiliates to screen for such individuals.

6. In addition, Planned Parenthood will have to spend significant staff time revising employment materials, conducting trainings with human resources personnel and supervisors, and retaining and paying outside legal counsel to advise on employment matters.

7. The Refusal of Care Rule puts Planned Parenthood affiliates at risk of losing hundreds of millions of dollars of federal funds. Many of PPFA's member-affiliates would be

forced to reduce their hours, cut their staff, and/or even close health centers if they lost all of their federal funding. This outcome would be devastating to Planned Parenthood and individuals who rely on us—especially people with low incomes, rural residents, and people of color who frequently have no other affordable option for high-quality and often life-saving reproductive care.

I. MY BACKGROUND

8. After receiving a B.A. from the University of Oregon, I held a series of management positions in the private sector. In 1997, I joined a Planned Parenthood affiliate as a Vice President for Community Affairs.

9. In 2004, I became the President and CEO for Planned Parenthood of North East Pennsylvania. For the next decade, I served as the chief executive of several Planned Parenthood affiliates.

10. In 2015, I accepted my current position as the Executive Vice President of the Health Care Division of PPFA. In this role, I oversee all health care programs for PPFA—including medical services, health education, health care operations, business analytics, accreditation, and evaluation for PPFA's affiliates—as well as affiliate governance and leadership. I also help develop short- and long-term strategies for affiliates to achieve their core mission of delivering high-quality reproductive health services.

II. PLANNED PARENTHOOD'S MISSION AND STRUCTURE

11. PPFA strives to ensure access to comprehensive reproductive health care services; advocates for public policies that support access to health care, especially for people who have low incomes or who are from underserved communities; and provides educational programs relating to reproductive and sexual health. PPFA also advocates for the right to access safe and legal abortion.

12. While PPFA is dedicated to ensuring access to comprehensive reproductive health care services, PPFA itself does not provide medical services. Medical services are provided by 53 Planned Parenthood affiliates in 48 States and the District of Columbia. These affiliates operate nearly 600 health centers across the nation, and they provide services to millions of patients from all 50 States and the District of Columbia each year.

13. PPFA is a not-for-profit corporation organized under the laws of New York and has its principal place of business in New York City (Manhattan). Our affiliates are members of PPFA, but each is a separately incorporated not-for-profit organization, with its own Chief Executive Officer and Board of Directors. Each affiliate provides medical and educational services in its community or communities.

14. In order to be certified as an affiliate and carry the Planned Parenthood name, each organization must satisfy the Standards of Affiliation laid out in PPFA's bylaws. Among other things, the Standards of Affiliation require that an affiliate publicly support the purposes and policies of PPFA and provide medical services that meet PPFA's Medical Standards and Guidelines ("MS&Gs"). For example, PPFA's MS&Gs and accreditation standards require that information that a patient needs to make an informed decision, including for abortion and sterilization, must be presented in an objective and nonjudgmental manner. Compliance with the MS&Gs is required to maintain affiliation with PPFA. Each affiliate is evaluated through PPFA's accreditation process at least every four years.

15. The member-affiliates set the long-range goals and priorities of PPFA and elect the PPFA Board of Directors. Through their participation and voting, PPFA's member-affiliates control the mission and direction of PPFA. Under PPFA's bylaws, PPFA's member-affiliates are also required to contribute financially to PPFA.

16. Affiliation with PPFA is important to the success of an affiliate. PPFA affiliates pay membership dues for the support, leadership, and guidance that PPFA provides, as well as the right to use the Planned Parenthood name and mark. The Planned Parenthood name signals that an affiliate stands for certain values and provides nonjudgmental, high-quality health care and educational services.

III. HEALTH CARE SERVICES PROVIDED BY PLANNED PARENTHOOD AFFILIATES

17. Each Planned Parenthood affiliate offers a wide range of family planning services and reproductive health care. These services may include contraception, including highly effective long-acting reversible contraceptives ("LARCs"); contraceptive counseling; physical exams; clinical breast exams; screening for cervical cancer; testing and treatment for sexually transmitted infections ("STIs"); pregnancy testing and counseling; colposcopies (a type of cervical cancer test); gender affirming care, including hormone therapy for transgender patients; some sterilization services, including vasectomies; abortion; and health education services. Availability of some of these services, including contraception, contraceptive counseling, and abortion, is a core part of Planned Parenthood's beliefs as an organization. Accordingly, the MS&Gs by which Planned Parenthood affiliates must abide require provision of these services.

18. In 2018, Planned Parenthood affiliates provided more than 9,800,000 services to approximately 2,400,000 patients during the course of approximately 4,000,000 visits. They provided reversible contraceptives to more than 1,800,000 patients and administered more than 560,000 cancer screenings and preventive services, such as breast exams and cervical screens (Pap tests). An estimated one out of every three women nationally has received care from a PPFA affiliate at least once in her life.

19. In the past several years, the occurrence of gonorrhea, chlamydia, and syphilis has dramatically spiked in communities nationwide, particularly in the communities that Planned Parenthood serves. Accordingly, STI testing and treatment has become a larger portion of Planned Parenthood's service mix. In 2018, our affiliates administered more than 4,900,000 STI tests, as compared to approximately 4,700,000 STI tests in 2017 and approximately 4,400,000 STI tests in 2016.

20. In my experience, there are many reasons why patients choose to receive care from PPFA affiliates rather than other providers of reproductive health care (when such alternative providers are available at all). Some patients choose Planned Parenthood because our expertise and specialization in reproductive health care make us the top choice for high-quality medical care.

21. Others choose Planned Parenthood because of our reputation for providing nonjudgmental and culturally sensitive care; Planned Parenthood staff are trained to acknowledge and respect patients' customs regarding reproductive health. Indeed, many of our patients receive their other health care from other providers, but because of privacy concerns and fear of judgment, they retain Planned Parenthood as a separate provider for their reproductive health care.

22. Our patients also turn to us for nonjudgmental and high-quality abortion care. Planned Parenthood affiliates are often the only abortion providers available; very few practicing OB-GYNs perform abortions, particularly OB-GYNs in private practice and those located in the Midwest and South. Moreover, of the relatively small number of OB-GYNs who do provide abortions, such services are not generally available but are instead reserved for existing patients. Today, 95% of abortions in the United States are performed in freestanding clinics, like the

health centers of Planned Parenthood affiliates. For this reason, abortion is a critical component of Planned Parenthood's mission.

23. Planned Parenthood health centers also tend to be much more convenient for their patients than other reproductive healthcare providers. Planned Parenthood affiliates can often see patients quickly—in many cases on a walk-in basis—whereas other providers frequently have long wait times for appointments.

24. Most Planned Parenthood health centers offer extended hours, which are especially important to patients with low incomes, many of whom have inflexible schedules due to work or childcare responsibilities. More than 80% of Planned Parenthood health centers offer appointments after 5 p.m. at least one day per week, nearly 60% offer appointments past 6 p.m. at least one day per week, and 45% offer weekend appointments.

25. In recent years, many Planned Parenthood affiliates have served a critically important role providing care, including hormone therapy, to transgender individuals. Planned Parenthood health centers are often the only place that these patients can access care without judgment or discrimination. In 2018, twenty-nine affiliates reported at least one health center providing gender affirming care.

26. Planned Parenthood affiliates also play a particularly important role in providing reproductive and other health care to individuals with low incomes. Most of PPFA affiliates' patients are poor and/or uninsured; approximately 73% have incomes at or below 150% of the federal poverty level. Fifty-six percent of affiliate health centers are in Health Professional Shortage Areas ("HPSAs") and/or in rural or other Medically Underserved Areas ("MUAs"), as designated by the Health Resources and Services Administration, a subagency of the U.S. Department of Health and Human Services ("HHS").

27. Planned Parenthood health centers also play a critical role in serving communities of color and in many cases are the only health centers providing reproductive health care in such communities. Approximately 26% of Planned Parenthood's patients are Latinx, 18% are Black, and 11% are Native American, Asian, or Multiracial. Over the past five years, Planned Parenthood has served an increasing number of patients in these groups.

IV. FEDERAL FUNDING RECEIVED BY PLANNED PARENTHOOD AFFILIATES

28. Almost all of Planned Parenthood's 53 member-affiliates receive federal funding. While the amount of federal funds varies by affiliate, many affiliates receive a significant portion of their budget from federal funds, and collectively, our affiliates have hundreds of millions of dollars at stake under the Refusal of Care Rule.

29. More specifically, almost all PPFA affiliates participate in Title XIX of the Social Security Act, more commonly known as the Medicaid program. The Medicaid program is a cooperative federal-state program that provides medical assistance to individuals with low incomes. These affiliates provide Medicaid-funded health care services to patients with low incomes at health centers all across the country. In 2017, Planned Parenthood affiliates received more than $418 million in Medicaid funds for reimbursement of services provided to Medicaid patients.

30. Further, Planned Parenthood provided family planning care in 2017 to an estimated 1.6 million patients in the Title X program. Title X, the federal program that subsidizes the provision of family planning services to people with low incomes, enables Planned Parenthood affiliates to offer these services on a sliding-fee scale, depending on the patient's ability to pay. Under Title X, the Secretary of HHS "is authorized to make grants and enter into contracts with public or nonprofit private entities to assist in the establishment and operation of

voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services." 42 U.S.C. § 300(a). These grantees may provide the program services themselves or contract with delegate agencies (or "subgrantees") to provide the services. Planned Parenthood affiliates serve as both direct grantees and subgrantees.

31. In 2017, Planned Parenthood affiliates received more than $67 million in Title X grants to support, for example, Pap tests, breast exams, and STI tests. Title X money is also used to support other critical needs that are not reimbursable under Medicaid or commercial insurance, like individual patient education, community-level outreach, and public education about family planning and related sexual health issues. Although Planned Parenthood affiliates only operate 13% of health centers in the Title X program, they serve 40% of the patients in the program.

32. PPFA affiliates also receive other HHS funds, including under the Social Services Block Grant ("Title XX" or "SSBG") program, which allocates funds to states to support social services for vulnerable children, adults, and families; the Maternal and Child Health Block Grant ("Title V") program, which supports the health of women, children, and their families; the Teen Pregnancy Prevention Intervention Grant ("TPPI") program, which funds organizations working to prevent teen pregnancy across the United States; the Ryan White AIDS program; and the National Breast and Cervical Cancer Early Detection Program ("NBCCEDP"). In 2017, Planned Parenthood affiliates received more than $3 million from SSBG, almost $2 million from Title V, more than $4 million from TPPI, more than $100,000 from the Ryan White AIDS program, and more than $350,000 from NBCCEDP.

33. It is my understanding that because of their receipt of these federal funds, PPFA affiliates will be required to sign a new certification that they are in compliance with the Refusal

of Care Rule and that failure to comply with the Refusal of Care Rule could lead to termination of all federal funding—which, as demonstrated above, amounts to hundreds of millions of dollars across the country.

V. BURDENS IMPOSED BY THE REFUSAL OF CARE RULE

34. Prior to the Refusal of Care Rule, whether Planned Parenthood affiliates were obligated to hire or accommodate individuals who expressed objections to performing job duties based on religious belief was governed by the standard for religious discrimination under Title VII of the Civil Rights Act, as well as by any obligations imposed by applicable state law. Under the Title VII standard, affiliates have no obligation to accommodate a religious objection if doing so would pose an undue hardship.

35. I understand that the Refusal of Care Rule, however, prohibits health care providers that receive certain federal funding, as our affiliates do, from "discriminating" against individuals who refuse to perform or assist in the performance of abortion, sterilization, and potentially other services, but makes clear that the Rule differs from Title VII by not incorporating the additional concept of an "undue hardship" exception for accommodations. I also understand that the Refusal of Care Rule prohibits Planned Parenthood affiliates from (1) asking *prospective* employees, interns, volunteers, and trainees whether they are willing to perform the essential functions of their job; (2) asking *existing* employees, interns, volunteers, and trainees if they object to the performance of any of their job functions more than once per calendar year absent an undefined "persuasive justification"—even in the event of an emergency; and (3) taking steps to protect patient access to the objected-to health services unless the objecting employee "voluntarily accepts" an undefined "effective accommodation" that does not amount to an "adverse action" or otherwise "exclude" the employee from a "field of practice." It

is my understanding that the Rule expressly declines to say whether a health care provider could disqualify a person with religious or moral objections to covered practices if such covered practices made up the primary or substantial majority of the duties of the person's position.

36. The Refusal of Care Rule's requirement that our affiliates accommodate the beliefs of employees, interns, trainees, and contractors at all costs, regardless of hardship to the affiliate, would mark a dramatic departure from our current practice. Planned Parenthood affiliates could be forced to hire and accommodate an unlimited number of individuals who refuse to provide or assist with abortion, sterilization, and potentially other core services we provide. This change in practice would jeopardize the ability of our patients to receive the nonjudgmental care and information they need, and in certain circumstances these accommodations would be impossible.

37. Accommodation would also impose significant security risks on Planned Parenthood affiliates, which may be forced to hire or accommodate individuals who are opposed to Planned Parenthood's mission and seek to sabotage our affiliates.

38. Finally, the Refusal of Care Rule grossly underestimates the costs Planned Parenthood affiliates would have to expend in order to revise employment practices and policies.

A. Burden on Staffing Practices and Effects on Service Offerings

39. Planned Parenthood affiliates employ thousands of individuals, and have a significant number of job vacancies at any given time. In 2018, PPFA affiliates had 8,857 full-time and 1,347 part-time employees, in addition to 31,544 volunteers.

40. Based on the number of employees replaced during the past several years, I estimate that Planned Parenthood affiliates make hiring decisions for approximately 2,000 employee vacancies per year.

41. Many of our affiliates have dealt with instances in which an employee, trainee, intern, volunteer, or applicant for a job has objected to providing or assisting with abortion care. Some have incurred costs—such as staffing changes or increased personnel—in accommodating these personal objections. Some affiliates have also experienced having an employee or applicant for a job object to providing gender affirming care to transgender individuals.

42. Accommodation issues like these often arise when an affiliate or health center expands or adds new services. For example, sometimes a health center that did not previously provide abortion services or gender affirming care adds these services, or an affiliate or health center expands its abortion services to later gestational ages. An individual sometimes indicates that he or she does not want to participate in the new services, including abortion and gender affirming care, and the affiliate must determine whether and how it is able to accommodate that individual.

43. Accommodating someone who objects to participating in the provision of a health care service offered by an affiliate can be very time-consuming and costly, especially for those affiliates with small health centers and/or those in remote locations. Many affiliates have very few individuals working at any particular health center at a time, and if one of those individuals is not willing to participate in providing a particular service, no other person may be available to take over his or her role. The impracticality of these objections is compounded by the fact that our affiliates cannot always predict which services will be provided on a given day or shift. In particular, patients seeking pregnancy testing or visiting us for another service in which a pregnancy diagnosis is possible need to have access to counseling about all of their options, including abortion. Some health centers also accept walk-in patients.

44. For many of our affiliates, if they were required to hire or accommodate someone who refused to provide or assist with abortion care, it would be difficult or prohibitively expensive to continue providing abortion services at one or more of their health centers. For example, I am aware that one affiliate currently has an employee who objects to abortion in a center with a small staff in a community with limited other options for abortion care, and it presents an ongoing challenge. Many of the affected health centers are located in areas without many other abortion providers, which would also negatively impact access throughout the region.

45. Similarly, for many affiliates, hiring or accommodating someone who refused to provide gender affirming care would make it difficult or prohibitively expensive to continue providing that care at one or more health centers.

46. While PPFA does not track precise figures, I know from my experience working with a wide range of affiliates and health centers that it is common for a health center to be staffed with a single licensed clinician. It is also common for a smaller health center to be staffed with only a very small number of total staff members. Accommodating all objections by employees, interns, trainees, and contractors would affect morale in some health centers.

47. Under the Refusal of Care Rule, affiliates must accommodate—or even hire and then accommodate—individuals in these jobs who refuse to participate in providing health care services that are central to the affiliates' mission to provide comprehensive, nonjudgmental reproductive health services. Such accommodation would be very expensive, time-consuming, and in certain instances, impossible.

48. The Refusal of Care Rule also increases affiliates' legal exposure for employment decisions it makes, even though Planned Parenthood has just cause to make those choices. For

example, a Planned Parenthood affiliate might choose not to hire an applicant because the applicant is unqualified—but if the applicant also happens to be opposed to providing abortion care, the affiliate will open itself up to risk of a complaint to HHS's Office for Civil Rights ("OCR"), which could lead to a loss of federal funding. The Refusal of Care Rule will force Planned Parenthood to substantially increase documentation related to hiring and other human resources decisions, adding further administrative burdens to each affiliate's practices.

49. If the Refusal of Care Rule is not enjoined, affiliates will be forced to hire some individuals they would not otherwise have hired under existing law. It will be very difficult, if not impossible, to unwind those hiring decisions after the fact. For example, some of our affiliates have staff who are members of collective bargaining units and whose employment is subject to the terms of those agreements.

B. Reputational Harms and Damage to Patient and Community Trust

50. If the Rule takes effect, it will also be detrimental to Planned Parenthood's reputation as a provider of compassionate and nonjudgmental care by sending a message to patients and communities that we cannot be relied on to provide that care consistently.

51. In particular, in many communities, we are already the last or among the last providers of abortion care, and patients seeking an abortion face severe community disapproval of their choice to have an abortion. They expect—and deserve—to come into one of our health centers and receive counseling about all of their options and, if they decide to terminate their pregnancy, to obtain abortion care without judgment by their providers. By condoning unlimited staff objections to provision of abortion care, the Rule would permit additional stigmatization of our patients seeking abortions, in turn damaging our reputation among patients.

52. In addition, to the extent that the Rule requires forced accommodation of staff who oppose emergency contraception, it will also harm our patients looking for readily available care to prevent an unintended pregnancy. These patients have five days or less to obtain contraception, and they come to us expecting that we will meet their needs, whatever those may be. If they are turned away by our providers, or told that they will have to obtain that care from someone else, our patients will get a message of disapproval—a message that is directly contrary to Planned Parenthood's standard of care and our longstanding reputation in communities we serve. The impact of these refusals will fall particularly hard on patients seeking emergency contraception after a sexual assault. We do not want to contribute further to the trauma these individuals have already experienced.

53. The reputational injury that PPFA and its affiliates will experience will be compounded by the fact that affiliates might not know if a staff member has refused to provide care or counseling for individuals on the basis of an objection. This lack of information will limit our ability to mitigate—as best we can under the circumstances—the impact of a provider's refusal on patient care by ensuring, if possible, that another staff member is able to care for that patient.

C. Increased Security Risks

54. I also have grave concerns that compliance with the Refusal of Care Rule could lead to security and privacy risks. Of course many individuals who might object to providing or assisting with our services pose no threat to our affiliates. However, it is critical that we be able to identify the subset of individuals who may seek positions with affiliates in order to infiltrate Planned Parenthood and use the information they gather or their access to our facilities to harm our staff, providers, and patients.

55. There is no limit to what people will do to infiltrate and sabotage Planned Parenthood. Individuals opposed to Planned Parenthood have filmed and harassed patients as they walked into health centers; recorded addresses of staff members and followed those staff members home; and contacted health centers under false pretenses—e.g., as a worker for a business providing services to an affiliate or as a staff member of a partner organization—in order to fish for information.

56. Many affiliates report that one or more individuals who they believed to be opposed to Planned Parenthood or the services Planned Parenthood provides have applied to work, intern, train, volunteer at, or contract with the affiliates. There have been instances in which abortion opponents filled out online applications for employment with us and in which an opposition member posted a job vacancy on her social media account and asked followers to apply.

57. Violence against abortion providers and abortion-providing facilities is not a new phenomenon.[1] However, it has spiked in recent years, following infiltration of Planned Parenthood in July 2015 by the anti-abortion Center for Medical Progress ("CMP"). CMP posed as a fake biomedical research company and filmed a series of undercover videos showing Planned Parenthood employees discussing fetal tissue donation. In July and August 2015, immediately following the release of the CMP videos, Planned Parenthood affiliates reported a sharp increase in threats, harassment, vandalism, and violence against them, their staff members, and their patients at health centers around the country—more than triple the number of incidents

[1] According to the National Abortion Federation, "there have been 11 murders, 26 attempted murders, 42 bombings, 185 arsons, and thousands of incidents of criminal activities directed at abortion providers" since 1977. National Abortion Federation, *2015 Violence and Disruption Statistics* 1 (2016), https://prochoice.org/wp-content/uploads/2015-NAF-Violence-Disruption-Stats.pdf [hereinafter "NAF Report"].

that affiliates reported in July and August of the previous year. Then, in November 2015, a man shot and killed three people and injured nine at a Planned Parenthood health center in Colorado Springs, Colorado, specifically noting that he was inspired by the anti-abortion rhetoric around fetal tissue donation.[2] The "2015 statistics reflect a dramatic increase in hate speech and internet harassment, death threats, attempted murder, and murder, which coincided with the release of heavily-edited, misleading, and inflammatory videos beginning in July."[3]

58. By preventing Planned Parenthood affiliates from identifying job applicants and other individuals seeking to work with us who oppose our mission, the Refusal of Care Rule would allow opponents to infiltrate our affiliates and obtain information or even film covert videos, which could lead to harassment, death threats, and murder, as it did in 2015.

59. The Refusal of Care Rule could further lead to harassment by allowing anti-abortion individuals to obtain employees' and patients' personal information. There are many websites where anti-abortion activists post photographs of staff members, along with photographs of their cars and homes, sometimes with addresses, license plate numbers, and private phone numbers. These posts expose our employees to harassment in their homes and neighborhoods. Anti-abortion activists often picket employees' homes, send graphic postcards to employees' home addresses, and even distribute pamphlets in employees' neighborhoods to "warn" neighbors that someone associated with abortion lives nearby. For this reason, many Planned Parenthood employees keep their affiliation with the organization private. Providing

[2] *See* Fred Barbash & Yanan Wang, *The Twisted 'Dream' of Accused Planned Parenthood Killer Robert Dear Jr.*, Wash. Post (Apr. 12, 2016), https://www.washingtonpost.com/news/morning-mix/wp/2016/04/12/the-twisted-remorselessness-of-accused-planned-parenthood-killer-robert-dear-jr/.

[3] *See* NAF Report at 1.

anti-abortion activists with additional access to Planned Parenthood affiliates and their staff would only exacerbate the harassment that our staff already face.

60. In addition, Planned Parenthood takes seriously its obligation to protect the privacy of patients who use its services, including services that may be stigmatized in the communities in which Planned Parenthood operates. By forcing Planned Parenthood to hire and accommodate individuals opposed to its mission, the Refusal of Care Rule could result in the release of private information—including names and addresses of patients—to individuals motivated to misuse it.

61. The release of information about patients and staff to individuals with ill will toward our organization could also result in an increase in abortion stigma in communities in which we provide services. As a result of stigma, individuals who provide or obtain abortion are labeled as different, stereotyped or associated with negative attributes, conceived of as an "other," and then subjected to status loss and discrimination. For providers and patients at Planned Parenthood affiliates, abortion stigma can lead to isolation, burnout, self-judgment, and physical and mental health consequences.

D. Review and Other Compliance Costs

62. The Refusal of Care Rule will also impose significant compliance costs on Planned Parenthood affiliates. I understand that HHS has estimated that family planning centers will spend (1) two hours on average familiarizing themselves with the Rule and its requirements, which represents a "one-time opportunity cost of staff time (a lawyer) to review the rule"; and (2) "an average of 4 hours [per year for the first five years] reviewing the assurance and certification language and the Federal conscience protection and associated anti-discrimination laws and the rule," which is "a function of a lawyer spending 3 hours reviewing the assurance

and certification and an executive spending one hour to review and sign." 84 Fed. Reg. at 23,240–41. I strongly disagree with these estimates.

63. As an initial matter, the time to review the Rule and associated laws is grossly underestimated. The Rule covers more than one hundred pages in the Federal Register, and the associated laws include not only the "Church, Weldon, and Coats-Snowe Amendments" but also "22 additional statutory provisions." 84 Fed. Reg. at 23,240. Affiliates would need to seek legal counsel to ensure that their policies and practices are in compliance with the Refusal of Care Rule. For counsel to thoughtfully review each of these documents would take several days—not several hours—of work. In addition, in states where there are potentially conflicting state laws, affiliates may need legal counsel to decipher whether those state laws have been preempted, or how the Rule and State laws operate in conjunction with each other.

64. In addition, because HHS requires additional protections under the Refusal of Care Rule than those that prevent religious discrimination under Title VII, Planned Parenthood affiliates will have to expend a significant amount of time and, in turn, money to revise their employment practices and policies in order to ensure compliance with the Rule.

65. In particular, I believe that nearly all affiliates would have to train any staff member with supervisory responsibilities on how to deal with hiring and accommodation requests in light of the Rule. PPFA affiliates have 1770 managers at nearly 600 locations across the country, and they may also need to train non-managerial staff who are involved in hiring.

66. In addition, affiliates will also have to review and revise employee manuals and handbooks to ensure that they are in compliance with the Refusal of Care Rule.

67. Similarly, all job descriptions, applications, and other employment recruitment materials will have to be reviewed line-by-line, and edited, where necessary. Again, each

affiliate's Human Resources Manager or Director will likely perform this task. I estimate that this will take at least 30 minutes for each job description and application, given the need to be detail-oriented when completing the task. As noted above, Planned Parenthood affiliates must make hiring decisions for approximately 2,000 employee vacancies per year.

E. Cost of Noncompliance

68. As high as the cost of compliance would be, the cost of noncompliance would be astronomical. Many of PPFA's affiliates would have to consider reducing their hours, their staff, or even closing health centers if they lost all of their federal funding. This would leave the vulnerable populations we serve without access to reproductive health care. As noted above, 73% of Planned Parenthood patients have incomes at or below 150% of the federal poverty level. Fifty-six percent of Planned Parenthood health centers are in HPSAs and/or MUAs. Planned Parenthood health centers also play a critical role in serving communities of color and in many cases are the only health centers providing reproductive health care in such communities. If Planned Parenthood affiliates lost all of their federal funding, the outcome would be devastating to the individuals who rely on us for their reproductive health care—especially patients with low incomes, rural patients, and patients of color who often have no other affordable option for reproductive care.

69. These draconian impacts on affiliates could occur based on noncompliance that is only tangentially related to us. It is my understanding that Planned Parenthood affiliates as well as their delegate agencies must comply with the Refusal of Care Rule, and that affiliates could lose their HHS funding if their delegate agencies or subcontractors were found not to be in compliance. In addition, where an affiliate is a subgrantee of a state agency, it could also lose all

of its federal funding if another subgrantee were to violate the Refusal of Care Rule—leaving the affiliate without federal funds even though it was in compliance with the Rule.

* * *

70. In sum, it is my belief that the Refusal of Care Rule will have a very large impact on the staffing practices of Planned Parenthood affiliates nationwide, the security of our providers and patients, and the nonjudgmental, compassionate patient care we are known for providing.

I declare under penalty of perjury of the laws of the United States that the foregoing is true and correct and that this declaration was executed on this 14th day of June 2019.

Kimberly Custer

EXHIBIT C

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., and PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, INC., Plaintiffs, v. ALEX M. AZAR II, Secretary of the United States Department of Health and Human Services, in his official capacity, *et al.*, Defendants.	Civil Action No. 1:19-cv-05433 Hon. Paul A. Engelmayer

DECLARATION OF MEAGAN GALLAGHER
IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Meagan Gallagher, declare and state as follows:

1. I am the President and Chief Executive Officer ("CEO") of Planned Parenthood of Northern New England, Inc. ("PPNNE"), a position I have held since 2013. As CEO of PPNNE, I lead the largest reproductive health care and sexuality education provider in northern New England. PPNNE's mission is to provide and protect access to reproductive health care and sexuality education so that all people can make informed, voluntary choices about their reproductive and sexual health. PPNNE operates 21 health centers across Vermont, New Hampshire, and Maine and serves more than 45,000 patients each year.

2. Before taking on my current role, I was the Senior Vice President of Business Operations at PPNNE. Prior to that I served as Chief Financial Officer, Chief Operating Officer, and Senior Vice President of Strategic Initiatives and Growth of the Planned Parenthood League of Massachusetts.

3. The facts I state here are based on my experience, my personal knowledge, my review of PPNNE business records, and information obtained through the course of my duties at PPNNE. If called and sworn as a witness, I could and would testify competently thereto.

4. I submit this declaration in support of Plaintiffs' Motion for a Preliminary Injunction, which seeks to enjoin the rule entitled "Protecting Statutory Conscience Rights in Health Care" (the "Rule"), 84 Fed. Reg. 23,170, issued by the U.S. Department of Health and Human Services ("HHS") on May 21, 2019. I am familiar with the Rule.

5. As explained below, the Rule presents a grave threat to PPNNE's mission and our ability to ensure that our patients have access to high-quality, comprehensive, and nonjudgmental care—regardless of the services our patients seek and regardless of their identity. The Rule will severely impair our operations, including our employment practices, and pose a threat to the security of our health centers. I am also deeply concerned about our ability to comply with the Rule's broad and vague requirements and understand that noncompliance could lead to loss of our federal funding. Loss of federal funding would do immense damage to PPNNE's ability to continue to provide quality, comprehensive family planning services to thousands of low-income individuals in northern New England.

BACKGROUND

A. PPNNE and Its Patients

6. Founded in 1965, PPNNE is a non-profit corporation incorporated in Vermont with headquarters in Colchester, Vermont. PPNNE is an affiliate of Plaintiff Planned Parenthood Federation of America ("PPFA"). Per PPFA's accreditation requirements, medical services at all Planned Parenthood affiliates must be provided in accordance with up-to-date, evidence-based standards of practice for family planning and reproductive health care. Affiliating with PPFA is critical to PPNNE's mission. It allows us to use the "Planned Parenthood" name, which patients

recognize as one attached to an organization that provides nonjudgmental, high-quality, and comprehensive reproductive health care.

7. Like other PPFA affiliates, PPNNE provides reproductive health care services as a "one stop shop." A patient can get an office visit, most relevant lab tests, and any needed drugs or supplies at one location without having to travel to a pharmacy or lab testing facility. This model is particularly important for the low-income patients served by PPNNE who often do not have the time, money, or resources to take time off work or school or to arrange alternative childcare necessary for these patients to make repeated medical visits. The "one stop shop" model increases the likelihood that patients will get their tests completed *and* take the medicines they are prescribed.

8. PPNNE offers education and counseling on reproductive health and provides comprehensive reproductive health care services. These services include birth control, such as emergency contraception and long-acting reversible contraceptives ("LARCs," the most effective form of birth control); testing and treatment for sexually transmitted infections ("STIs"); testing for HIV and the HPV virus; pregnancy testing; breast and cervical cancer screenings; and safe and legal abortion. PPNNE's abortion care includes medication abortions through 11 weeks after the first day of a patient's last menstrual period and surgical abortions through 19 weeks. In addition, all PPNNE health centers offer PEP and PReP for HIV prevention; gender affirming care, including hormone therapy for transgender patients; prenatal screenings and referrals; and referrals for sterilizations (e.g., vasectomies).

9. In 2018, PPNNE served more than 45,000 patients at more than 67,000 patient visits. These services included approximately 8,500 pregnancy tests; 6,300 LARC insertions; provision of 73,000 packs of birth control pills; 61,000 instances of screening and/or treating STIs,

including chlamydia, gonorrhea and syphilis; 10,000 HIV tests; 2,000 prescriptions for emergency contraception, including for individuals who were victims of sexual assault; and about 3,500 abortion procedures.

10. Most of PPNNE's patients have low incomes. In 2018, 47 percent of its patients in Vermont, 55 percent of its patients in New Hampshire, and 57 percent of its patients in Maine had incomes at or below 150 percent of the federal poverty level.

11. A large portion of our patients are on Medicaid: approximately 29 percent who visit a Vermont health center, 28 percent who visit a New Hampshire health center, and 14 percent who visit a Maine health center.

12. Many of our patients are uninsured or underinsured. In 2018, for example, 20 percent of our patients did not pay for services using some form of public or private insurance, a strong indicator of insufficient insurance access.

13. PPNNE serves a significant number of rural patients, as Vermont, Maine, and New Hampshire are all states with large rural areas.

14. Several of PPNNE's health centers serve areas that have been designated by the Health Resources and Services Administration ("HRSA"), an HHS subagency, as medically underserved in some manner or as experiencing a provider shortage. Those health centers include facilities in Sanford and Portland, Maine; Manchester, Claremont, and Keene, New Hampshire; and Burlington, St. Johnsbury, and Newport, Vermont.

15. PPNNE health centers are staffed with experienced practitioners. We employ physicians, advanced practice clinicians (physicians' assistants, nurse practitioners, certified nurse midwives), registered nurses, and medical assistants. Each operates within their particular, authorized scope of practice so that health care services are delivered as efficiently and cost-

effectively as possible. While not all of our practitioners have the skills and training to provide every service we offer, such as abortion services, we expect all of our practitioners to be able and willing to provide patients with accurate information about our services or refer them to a practitioner who can provide such information.

16. PPNNE currently employs about 240 individuals, including full-time staff, part-time staff, and contract workers. We also currently have interns, trainees, and contractors who help facilitate and provide patient care and fulfill our mission. While I would not consider all of these individuals PPNNE staff, throughout this declaration, I include within the term "staff" all such individuals, in addition to our employees, given the broad definitions in the Rule.

17. In 2018, we posted about 90 job openings and had 58 interns and approximately 1,000 volunteers. Currently, PPNNE has 26 job openings and 16 positions for interns and volunteers that we are actively seeking to fill, including positions at a number of our smaller health centers that are more leanly staffed.

B. PPNNE's Federally Funded Services

18. PPNNE receives a significant amount of federal funding; in 2018, those funds accounted for $6.7 million, or 28 percent, of PPNNE's total revenue. This total includes both federal grants and payments from Medicaid and Medicare.

19. The federal grant program from which PPNNE receives the most funding is the Title X program, which subsidizes the provision of family planning services to low-income people. Under Title X, HHS "is authorized to make grants and enter into contracts with public or nonprofit private entities to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services." 42 U.S.C. § 300(a). Title X grantees may provide the program services themselves or contract with delegate agencies (or "subgrantees") to provide the services. PPNNE receives a direct Title X grant

in New Hampshire and is a subgrantee in Vermont and Maine.

20. Services provided under the Title X program include contraceptive services and counseling, pelvic exams, pregnancy testing and counseling, testing for STIs and HIV, screening for breast and cervical cancer, and certain basic infertility services. With respect to contraception, the Title X guidelines say that Title X projects should "make available to clients all methods of contraception approved by the Federal Food and Drug Administration," including oral contraceptives, IUDs, and emergency contraception. In addition, each Title X project must "[o]ffer women the opportunity to be provided information and counseling regarding each of the following options: (A) [p]renatal care and delivery; (B) [i]nfant care, foster care, or adoption; and (C) [p]regnancy termination." 42 C.F.R. § 59.5. Title X permits entities that provide abortions to receive Title X funds for a family planning project, provided that those entities maintain programmatic and financial separation between the subsidized project and their abortion services and the project does not include "abortion as a method of family planning." 42 U.S.C. § 300a-6.

21. Under PPNNE's current Title X grant and subgrants, we receive $1.9 million a year to provide family planning services to low-income individuals throughout the region.

22. PPNNE also receives approximately $313,000 a year of federal funding from the state of Vermont under the Social Security Block Grant ("SSBG" or "Title XX") program, 42 U.S.C. § 1397 *et seq*., to provide family planning services. The SSBG program is administered by HHS to provide funds for each State to furnish social services best suited to meet the needs of its residents.

23. PPNNE receives approximately $400,000 a year in additional funding from other HHS programs as well.

24. In addition, all of our health centers provide care to patients who receive Medicaid benefits or who are insured via Medicare. The annual Medicaid and Medicare payments to PPNNE total approximately $2.7 million.

25. PPNNE is also partnering with a team of researchers from local universities and states to provide phlebotomy services for the Drug Injection Surveillance and Care Enhancement for Rural Northern New England study (DISCERNNE). This study is funded in part by the National Institute on Drug Abuse, within HHS's National Institutes of Health.

26. Therefore, PPNNE and its patients have a lot at stake under the Rule. If PPNNE were found to be out of compliance with the Rule, we could lose more than $6.7 million—or approximately 28 percent of our revenue. HHS provides Title X funding to Maine Family Planning, which provides subgrants to PPNNE and other entities; it is my understanding that a compliance action against one of those other subgrantees could place PPNNE's funding at risk.

THE RULE'S IMPACT ON PPNNE AND ITS PATIENTS

27. There are several aspects of the Rule that are deeply troubling. If PPNNE is forced to implement the Rule, it will interfere with and frustrate PPNNE's mission to champion and promote quality sexual and reproductive health, and will put patients at risk of being denied care and information about the services they seek.

28. First, I understand that under the Rule, any individual who works at PPNNE—including clinicians, volunteers, trainees, and contractors—has the right to refuse to provide or assist with abortion or sterilization services, and potentially other services we provide, if that individual claims a religious or moral objection. The Rule also broadly defines "assisting in the performance" of a particular service to sweep in a universe of activities that may be refused, including but not limited to "counseling, referral, training, or otherwise making arrangements" for the procedure or service. I also understand that the Rule does not incorporate the "undue hardship"

exception to religious accommodations from Title VII, and instead appears to require absolute accommodation of employees' objections—even as to core health services that our patients rely upon us to provide.

29. Second, I understand that the Rule includes a definition of "discrimination" that, among other things, would prohibit PPNNE from asking prospective employees, interns, volunteers, and contractors about whether they have an objection to performing or assisting in the performance of abortion or sterilization, and possibly other services, prior to finalizing the employment or work relationship. The Rule's restrictions on questions we can ask during pre-employment and other screening interviews increases the likelihood that we will have to accommodate individuals who refuse to provide certain care and for whom we would not currently be required to provide accommodation.

A. The Rule Threatens Patient Access to Care and Is Not Workable for Our Health Centers.

30. Currently, PPNNE has a policy of providing accommodations that allows us to balance our obligations to accommodate employees' religious beliefs and practices, including their refusal to participate in specific health care services, with the needs of the patients we serve. This Rule upends that careful balance and instead forces us to put our patients' needs second to those who wish to deny them care.

31. Accommodating a blanket refusal by one of our staff to perform or assist in the performance (as broadly as that is defined) of all abortions or another reproductive health care service that we provide, as the Rule appears to require, would be very burdensome for PPNNE given the manner in which we provide health care. On any given day we may see patients who are seeking STI treatment, abortion care, gender affirming care, or any of our other services. Our clinicians are expected to provide the services our patients require (within the limits of their

training) and to do so in a compassionate, nonjudgmental manner.

32. Moreover, we may not know in advance every service that will be provided on a given day or shift. We allow for walk-in patients, and even our scheduled patients may come in for one service but ultimately need or request other health care or information about different health services.

33. For example, a patient who comes in for pregnancy testing may discover she is pregnant. PPNNE provides ethical, non-directive pregnancy counseling in the following ways: Patients are asked about their feelings about their pregnancy. PPNNE health care providers use open-ended questions to best understand what options each patient may pursue, and make sure that, when the patient is unsure, she understands all options: parenting, adoption, and abortion. Patients are given resources according to the option(s) they express interest in, and for all options if they are undecided. This non-directive pregnancy counseling often requires referrals for particular pregnancy services, including abortion, on request of the patient. When making referrals, PPNNE providers are open and transparent with patients about which referral partners provide which services, consistent with medical and ethical standards. PPNNE providers only provide information about or refer patients for services that patients have indicated they are interested in receiving or learning more about.

34. Forcing PPNNE to accommodate individuals who refuse to provide care will be especially burdensome for our patients seeking abortion care. Abortion care is an extremely stigmatized health service that patients can only access at a very limited number of providers. Our society and culture already make people feel bad about the decision not to carry an unwanted pregnancy to term. Indeed, there are often protestors outside PPNNE's health centers who shame patients for their reproductive choices. But when people walk through our doors, they know our

health centers are a safe space for them to talk about *all* of their options without judgment. If our patients were to encounter someone at our health centers who would not provide them information about or provide the procedure itself, they would be further stigmatized. Most of our patients would have nowhere else to turn.

35. The forced accommodations required by the Rule will also be detrimental to our patients who seek access to emergency contraception, including our patients who are victims of sexual assault. Emergency contraception is birth control that an individual can use to prevent pregnancy up to five days after unprotected sex. Depending on a patient's circumstances, she may need a form of emergency contraception that requires a visit to a health care professional and a prescription. By the time some patients reach us to obtain emergency contraception, they may have only a short window remaining to utilize this form of care, and any further delay could result in unintended pregnancy. To the extent that the Rule could be interpreted to require accommodation of staff who object to the provision of emergency contraception, the Rule would imperil these patients' health.

36. Moreover, under the Rule, we might not know if one of our staff is refusing to provide information or services. As I understand it, under the Rule, an individual could decline even to tell the patient that the individual has withheld full information about the range of available and recommended medical options. This aspect of the Rule could have a devastating effect on a person's health and life. A clinician who declines to provide all relevant medical information and options to a patient and refuses to refer that patient to someone who will, or who privileges a personal view over the scientific consensus, could no longer be counted on to adequately serve our patients.

37. Even assuming we could withstand keeping on staff someone who refuses to provide or assist with the core reproductive services we are known for providing, we would have to radically revise our work schedules or send clinicians to different health centers (assuming that is legally permissible under the Rule, as I explain below) to account for the limitations in the services a clinician is willing to perform.

38. Accommodating individuals who have an objection to providing or assisting with a core health service would be nearly impossible at some of our health centers that employ only a few individuals. PPNNE has 18 health centers where there is only one licensed clinician at any given time, and that person is expected to provide a full range of reproductive health care, including contraception, emergency contraception, and medication abortion. We also have eight health centers that generally have only three individuals on staff at a given time: a clinician, a front-office staff member, and a healthcare assistant who, for example, takes patients' vital signs and medical histories.

39. A refusal by any one of the individuals at one of these small centers to perform or "assist in performing" an abortion, pregnancy testing, birth control counseling, or other reproductive health care services would make it very difficult and costly, if not impossible, for those health centers to continue providing the full scope of reproductive health care currently offered. For example, if the front-desk staff person had an objection to scheduling or checking in patients who seek abortion services, there would be no way to accomodate this person because there may be no other staff member working who has the knowledge and training to play that role. The same would be true for the one clinician who is responsible for caring for all the patients seen on that clinician's shift, and for the person in the back of the health center who is responsible for taking vital signs, medical history, etc. for all patients. There may be no one else who can step in

to do these individuals' jobs if they refuse to care for a patient.

40. Accordingly, depending on the scope of the objection, the responsibilities of the staff person, and the nature of the health center's capacity, an objecting individual could force us to cut services and turn away patients, potentially resulting in reduced hours, elimination of staff positions, and closure of health centers.

B. The Rule Will Harm PPNNE's Reputation and Reduce Patient and Community Trust in PPNNE.

41. The Rule will also injure PPNNE's reputation in communities we serve and damage patient goodwill and trust. We are trusted by patients and the communities we serve to provide nonjudgmental, science-based counseling on reproductive health and sexuality. Indeed, in many areas that our health centers are located, we are the only health care provider that provides such counseling and care.

42. We have had patients tell us that they seek care at our health centers because they know we provide nonjudgmental care and will provide patients with information about all of their options. This is especially true for our patients who come in with or suspect that they have an unintended pregnancy and who are looking for information about abortion.

43. It is critical to our mission and reputation that the counseling services we provide be accurate, science-based, and balanced. If patients are not receiving complete, science-based information about their reproductive health options, it will undermine patients' trust in PPNNE, and result in a loss of goodwill in the community. Similarly, if patients encounter staff at our health centers who refuse to care for them or provide them with the information they are seeking, they are likely to feel stigmatized and lose trust in Planned Parenthood.

C. The Rule Poses a Security Threat to PPNNE and Its Staff and Patients.

44. Planned Parenthood's mission is to provide comprehensive reproductive and

complementary health care services and information in settings that preserve and protect the essential privacy and rights of each individual. For this reason, PPNNE has developed a screening process for employees and other staff members to ensure we work with qualified individuals who are committed to providing nonjudgmental care to all patients—regardless of the services they seek and their identity. A key aspect of the screening process is determining whether prospective employees, interns, trainees, and contractors are actually willing to provide or assist with the health services that we offer to our patients.

45. We also view our screening process as essential to maintaining the safety and security of PPNNE, its staff, and its patients. PPNNE has developed procedures to screen out applicants who may pose a security threat. Although certainly not all individuals opposed to providing or assisting with services we provide have bad intentions, it is a sad reality that there are individuals who strongly oppose Planned Parenthood because we provide abortion services and they will take extreme action to obstruct the delivery of abortion services and even hurt those providing abortion services. Several of our health centers have been targeted by anti-abortion protestors, and anti-abortion advocates have posted the name of PPNNE's medical director on a website that encourages people to harass anyone associated with abortion. Other affiliates and PPFA, our national office, have also been the subject of large-scale operations to sabotage Planned Parenthood by individuals whose mission is to destroy the organization. Abortion providers have been harassed and even killed. Thus, we take the security of our staff, their families, our patients, and organization very seriously.

46. We have had individuals in the past apply for a job with PPNNE who we believed to be opposed to Planned Parenthood or the services Planned Parenthood provides, but through our screening processes were able to detect their true motives and prevent them from being hired.

47. It is my understanding that the Rule prohibits us from asking applicants basic questions about whether they have objections to providing or assisting with any service. As a result, the Rule will fundamentally alter the screening processes I described above, which depend on our ability to ask these questions of applicants.

48. The required changes to our screening process will impair our mission, forcing us to bring on board a potentially unlimited number of staff who are unwilling to perform core aspects of their jobs and our services. The Rule will also pose a security threat by limiting the tools at our disposal to root out applicants with malicious intentions; these individuals, if hired, may have access to our staff and patients, including our patients' most private health information. I also fear that under the Rule even more such individuals will apply for jobs at PPNNE because they will know that we cannot affirmatively ask them in the screening process whether they object to providing or assisting with our services.

D. The Rule Permits Conduct Inconsistent with Our Providers' Professional Obligations.

49. Planned Parenthood's Medical Standards & Guidelines clarify that health care providers must inform their patients about *all* relevant options for treatment—regardless of whether the provider finds any of those options morally objectionable—in order to abide by the principles of informed consent. If physicians have religious or moral objections to providing a particular procedure, their ethical obligation is to refer patients to another provider who will treat them. In emergency situations in which a referral is not possible, they must provide the care the patient requires.

50. By allowing health care workers to refuse to provide patients with care or information about their options, even in emergencies, the Rule would facilitate a violation of these foundational principles of ethics—elevating health care workers' personal beliefs above their

patients' health. For example, a health care worker may refuse to provide gender affirming care to a transgender patient on religious or moral grounds, leaving that individual without necessary care in the short term, and discouraged from accessing other health care in the long term. And if a health care worker at one of our leanly staffed, rural health centers refused to provide a pregnant patient with information about all of her options, including abortion, the patient could be prevented from accessing abortion until later in pregnancy, when risks of complication are higher. The pregnant patient may even be delayed past the point in pregnancy when abortion is available in her state. In all these instances, the health care workers would be putting their personal beliefs above a patient's health, or even life.

E. The Rule Will Impede Our Patients' Access to Care That Depends on Other Entities.

51. In addition to threatening patient care offered directly by PPNNE, the Rule, once effective, would impair our patients' access to care that depends on other providers. For example, while abortion is a very safe medical procedure, some of PPNNE's abortion patients who experience complications need to seek care at hospitals. Other patients are not experiencing a complication, but are concerned about signs or symptoms and will seek care at hospitals or with other providers. I am worried that if the Rule takes effect, these patients may be denied care by a practitioner who refuses to treat them because they are seeking care related to an abortion.

52. In addition, a patient who chooses to continue her pregnancy to term may either spontaneously abort (this is commonly called miscarriage), or develop a medical complication so serious that it is medically advisable to terminate the pregnancy. These patients need to have their pregnancies ended or their abortions completed and a denial of care could threaten their lives, health, or future fertility.

53. The substantial percentage of PPNNE's patients who rely on health insurance may also face impediments to care erected by insurance companies and permitted by the Rule. For example, Vermont has a law that requires group health insurance plans sold in the state to provide coverage for contraceptive drugs and devices if the plan provides prescription drug coverage. I am concerned that some insurance companies may refuse to provide contraception for reasons they deem permitted by the Rule, frustrating patient access to care. If an insurance company does not reimburse for contraception, our health centers would bill the patient on a sliding-fee schedule, potentially at increased cost to the patients.

F. The Rule Will Force PPNNE to Expend Substantial Resources for Compliance.

54. I understand that, under the Rule, PPNNE will have to certify compliance with the Rule, even though there are many aspects of compliance that we simply do not understand.

55. If the Rule takes effect, we will have to review and revise our interviewing processes and our guidelines for supervisors, and revise and reprint our employee personnel manual—all of which will take a significant amount of staff time. We will also need to organize and conduct new trainings for human resources staff and supervisors who handle personnel matters at all of our health centers about our obligations under the Rule. Any such significant policy changes require legal review, and we will likely need to obtain outside employment counsel.

56. In addition, we will most certainly have to seek legal advice to help us navigate all the questions the Rule raises but does not address. For example, the Rule raises serious questions about our training regime. Currently, all of our clinicians are trained in the basics of abortion care and contraceptive care. In addition, we provide ongoing training to our clinicians, including by having a site manager or assistant site manager observe a clinician to assess his or her competency in counseling patients.

57. The Rule also raises questions about whether Planned Parenthood must keep on staff individuals who refuse to perform primary job functions, whether patients can be denied care or information even in emergency or life-threatening situations, and what is a "persuasive" enough justification for inquiring about employee objections more than once per year. It also does not address what would happen if an employee developed an objection after having already told the employer that he or she has no objections.

58. The Rule also does not clarify how far an employer must go to accommodate an objector to avoid unlawful discrimination. For example, must an employer take religious objections into account when making scheduling decisions, or would that instead be considered discrimination? Is an employer allowed to require employees to tell someone when they have refused to provide care to a patient? Similarly, the Rule says that "an entity subject to any prohibition in this part shall not be regarded as having engaged in discrimination against a protected entity where the entity offers and the protected entity [e.g., an employee or volunteer] voluntarily accepts an effective accommodation for the exercise of such protected entity's protected conduct, religious beliefs, or moral convictions." 84 Fed. Reg. at 23,263. But it is unclear what providers should do when an employee does not "voluntarily accept[]" an offered accommodation and instead demands an accommodation that would put patients at risk or otherwise compromise patient care.

59. In addition, I understand that the Rule states: "The employer may also inform the public of the availability of alternate staff or methods to provide or further the objected-to conduct, if doing so does not constitute retaliation or other adverse action against the objecting individual or health care entity. For example, an employer may post such a notice and a phone number in a reception area or at a point of sale, but may not list staff with conscientious objections by name if

such singling out constitutes retaliation." This simply does not provide any guidance and instead suggests that were we to post such notice we could be found to have engaged in discrimination and risk that an enforcement action be taken against PPNNE.

THE IMPACT OF A LOSS OF FEDERAL FUNDING ON PPNNE

60. Given the breadth of the Rule and the numerous unanswered questions about how we must comply with the Rule, I am very concerned that we may run afoul of the Rule's onerous and vague requirements. If PPNNE lost federal funding, we would not be able to continue our operations as they exist today. Our health care centers are already operating at a budget deficit. While we currently are able to cover these gaps through temporary measures and fundraising, we would not be able to make up for the loss of all or a significant portion of our federal funding.

61. A complete loss of federal funding would likely result in a significant decrease in our size and ability to provide health care services to our patients. We estimate that it would require the closure of between 8 and 11 health centers, which would likely impact between 11,000 and 19,000 patient visits. We would likely have to eliminate staff positions in those health centers as well as reduce our administrative and centralized support staffing. In addition to these closures, we would have to consider reducing our hours and staffing at the remaining health care centers, and/or increasing what we charge for our services.

62. If PPNNE had to close health centers, reduce hours, reduce staffing, or increase its fees, these changes would significantly undermine (and at a minimum, delay) low-income individuals' access to the critical reproductive health services we provide. There are not enough other health care providers in the region to take care of our patients if we are forced to cut back. In particular, other providers in our communities do not have the capacity to take our Medicaid patients, nor do I believe they would want to do so given Medicaid reimbursement rates.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct and that this declaration was executed on June 13, 2019.

Meagan Gallagher

EXHIBIT D

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION; and PUBLIC HEALTH SOLUTIONS, Plaintiffs, v. ALEX M. AZAR II, in his official capacity as Secretary of the U.S. Department of Health and Human Services; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROGER SEVERINO, in his official capacity as Director of the Office for Civil Rights of the U.S. Department of Health and Human Services; OFFICE FOR CIVIL RIGHTS of the U.S. Department of Health and Human Services, Defendants.	CIVIL ACTION NO. 19-cv-05435 (rel:19-cv-04676-PAE; 19-cv-05433-PAE)

DECLARATION OF CLARE M. COLEMAN

I, Clare M. Coleman, declare and state the following:

1. I am the President and CEO of the National Family Planning & Reproductive Health Association ("NFPRHA"), a Plaintiff in this action. I submit this declaration in support of Plaintiffs' motion for a preliminary injunction barring enforcement of the Department of Health and Human Services ("HHS") regulation entitled: Protecting Statutory Conscience Rights in Health Care, 84 Fed. Reg.

23,170 (May 21, 2019) (to be codified at 45 C.F.R. pt. 88) (the "Health Care Refusal Rule" or the "Rule"). A preliminary injunction would preserve the *status quo* during the pendency of this case and allow NFPRHA's members to continue to provide quality family planning and other critical health care services to low-income patients as they have for decades, and prevent the Health Care Refusal Rule from disrupting and undermining the provision of this critical health care.

2. I submit this declaration to provide information about NFPRHA's membership, on whose behalf it sues, and the Title X program. I also set forth facts showing the irreparable harms that will ensue if the Health Care Refusal Rule is allowed to take effect. These harms will affect not only Plaintiffs—including their clinicians and their patients—but also the general public health across the country.

MY BACKGROUND AND EXPERTISE

3. I have led NFPRHA for nearly ten years. Prior to assuming NFPRHA's leadership, I was President and CEO of Planned Parenthood Mid-Hudson Valley, a Title X provider with, at that time, 11 health centers in a four-county area. At Planned Parenthood Mid-Hudson Valley, I directed a 110-person staff, the majority of whom were dedicated to providing clinical services, and I oversaw the organization's $9 million operating budget.

4. My work experience also includes significant time as a senior staff

person on Capitol Hill, with an emphasis on health care and appropriations-related efforts, and as a legislative representative for Planned Parenthood Federation of America.

5. As discussed below, from 2010 to 2014, the Centers for Disease Control and Prevention ("CDC") and HHS's Office of Population Affairs ("OPA") (the HHS office responsible for Title X family planning) developed a joint publication on how to provide quality family planning services. That document, "Providing Quality Family Planning Services," is now referred to in the field as "the QFP."[1] In developing these new national clinical standards for family planning care, CDC and OPA worked with various panels of outside experts.

6. The Acting Director of OPA appointed me to serve as a member of the Expert Working Group that advised the CDC and OPA throughout their development of the QFP. The Expert Working Group advised on the structure and content of the QFP recommendations and helped make those recommendations as feasible and relevant to the needs of the field as possible.

7. Through my professional experience, my interactions with NFPRHA members and with OPA and other federal agencies, my related work with Congress, and my review of literature and historical material, I am well-versed in

[1] Centers for Disease Control and Prevention & Office of Population Affairs, *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs* (Apr. 2014), https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf (hereinafter "QFP").

the history of Title X, all aspects of Title X programs (including best practices for providing family planning services and ensuring compliance with federal funding restrictions), and the process of Title X grant-making, and am regarded as an expert in the field.

8. This declaration is based upon my personal knowledge, experience, and expertise.

NFPRHA AND ITS MEMBERSHIP

9. NFPRHA is a national, non-profit membership association that advances and elevates the importance of family planning in the nation's health care system and promotes and supports the work of family planning providers and administrators, especially those in the safety net (i.e., those providing publicly funded care). The interests that NFPRHA seeks to vindicate in this suit are central to its mission. NFPRHA is the lead national advocacy organization for the Title X family planning program, and it works to maintain Title X as a critical part of the public health safety net. NFPRHA envisions a nation where all people can access high-quality, client-centered, affordable, and comprehensive family planning and sexual and reproductive health care from providers of their choice.

10. In addition to its Title X advocacy, NFPRHA provides education, expert resources, and technical assistance to Title X grantees and sub-recipients, and concretely supports the work of those entities on an ongoing basis as they

implement Title X. In addition to its direct membership assistance, NFPRHA's meetings and conferences enable members to share expertise and experiences. If necessary, NFPRHA engages in litigation to ensure that Title X operates lawfully. Among other efforts, NFPRHA also advocates for and supports maintaining access to abortion services and works to advance health equity by eliminating barriers that contribute to disparities in health care access.

11. NFPRHA represents more than 850 health care organizations in all 50 states, the District of Columbia, and the U.S. territories, and also includes in its membership individual professionals with ties to family planning care. NFPRHA's organizational members include state, county, and local health departments; private non-profit family planning organizations (including Planned Parenthood affiliates and many others); family planning councils; hospital-based health practices; and federally qualified health centers ("FQHCs"). One of NFPRHA's members is Plaintiff Public Health Solutions.

12. NFPRHA currently has more than 65 Title X grantee members and almost 700 Title X sub-recipient members. NFPRHA member organizations operate or fund a network of more than 3,500 health centers (93% of Title X-funded service sites) that provide family planning services to nearly 3.7 million Title X patients (94% of patients served in Title X-funded sites) each year.

13. The majority of these patients live on income levels at or below the

poverty line and are uninsured or underinsured. In 2017, 90% of Title X users had family incomes that qualified them for either subsidized or no-charge services. Forty-two percent of Title X users were uninsured, which is more than triple the national rate for adults (13%).[2] If they were not able to obtain care at the health centers associated with NFPRHA members, many of these patients would have no other access to family planning services.

14. The services NFPRHA members provide include contraceptive education and counseling; a wide range of contraceptive services, including provision of birth control pills, emergency contraception, and intrauterine contraceptives (commonly called IUDs); breast and pelvic exams and cervical cancer screening; education on health promotion and disease prevention; pregnancy testing and non-directive pregnancy options counseling and referrals; screening for, and treatment of, sexually transmitted infections; and HIV testing and counseling. In addition to providing family planning services, some NFPRHA members also provide a range of other reproductive and primary health care services including prenatal care and abortion services.

15. In addition to Title X funding, many of NFPRHA's organizational members and their network of health centers accept Medicaid. Medicaid, Title

[2] Office of Population Affairs, *Title X Family Planning Annual Report: 2017 National Summary* (Aug. 2018), https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2017-national-summary.pdf (hereinafter "2017 FPAR").

XIX of the Social Security Act, 42 U.S.C. § 1396, is a joint federal-state program that provides reimbursement to health care providers for the provision of health care services, including family planning services, to low-income individuals. In 2017, Medicaid paid for $495 million worth of services provided by entities that receive Title X funding.

16. Additional federal funding sources administered by HHS help finance services provided by many NFPRHA members, including the Title V Maternal and Child Health Block Grant (a federal-state partnership to supplement health care for mothers, children and their families); Title XX Social Services Block Grant (grants to enable states to fund a range of social and health services); Temporary Assistance to Needy Families (grants to states to provide cash assistance, education and direct services, including family planning, for needy families); the Ryan White HIV/AIDS Program (the largest federally funded program for low-income, uninsured, and under-insured people living with HIV/AIDS); CDC's STD program funds (grants to all states and certain cities with high STD prevalence rates); State Children's Health Insurance Program (federal matching funds to states to expand health care coverage for uninsured children); and grants under Section 330 of the Public Health Services Act to provide primary health care services to underserved populations.

17. NFPRHA members also receive federal funding administered by

agencies other than HHS, which would nonetheless be at risk under the Rule. This includes, for example, the Special Supplemental Nutrition Program for Women, Infants, and Children ("WIC"), which is administered by the Department of Agriculture.

HISTORY AND STRUCTURE OF THE TITLE X PROGRAM

18. Title X is the only dedicated source of federal funding for family planning services in this country. Title X became law as part of the "Family Planning Services and Population Research Act of 1970." Pub. L. No. 91-572, 84 Stat. 1504 (1970).

19. Title X was enacted with overwhelming bipartisan support. In 1969, President Richard M. Nixon called on Congress to "establish as a national goal the provision of adequate family planning services … to all those who want them but cannot afford them," stressing that "no American woman should be denied access to family planning assistance because of her economic condition." President Richard M. Nixon, Special Message to the Congress on Problems of Population Growth (July 18, 1969).

20. However, Congress also recognized that, in this area of individuals' reproductive decision-making, there must be "explicit safeguards to insure that the acceptance of family planning services and information relating thereto must be on a purely voluntary basis by the individuals involved." S. Rep. No. 91-1004, at 12

(1970). Thus, through Title X, Congress sought to provide low-income patients with biomedical contraceptives, with equal access to high-quality family planning medical care, and with the true freedom to make their own decisions about whether and when to have children. Those purposes remain the Title X program's central focus.

21. Indeed, every year from 1996 to the present, in making appropriations for Title X, Congress has reiterated that it must fund only *voluntary* family planning projects. This echoes two sections of the original Title X enactment. 42 U.S.C. §§ 300, 300a-5. In addition, every year from 1996 to the present, Congress has mandated that within the Title X program, "all pregnancy counseling shall be nondirective." *See* HHS Appropriations Act, 2019, Pub. L. No. 115-245, 132 Stat. 2981, 3070-71 (2018).

22. Section 1001 of the statute provides for the funding of competitive grants to public or nonprofit private entities to assist in the establishment and operation of voluntary family planning projects, *see* 42 U.S.C. § 300, and those projects are Title X's means of service provision to individuals.

23. In every fiscal year from 2015 to 2019, Congress has appropriated $286,479,000 annually for Title X purposes. Of that, HHS distributes approximately $260 million annually in grants under Section 1001 to fund Title X family planning services.

24. HHS awards grants to fund Title X care in geographic service areas throughout the country and in the U.S. territories. Within each project funded by Title X, there are typically three levels: the grantee, sub-recipients, and individual service sites.

25. Title X coverage across the nation, whether urban, rural, or suburban, is wide. In 2010, the Guttmacher Institute reported that 72% of U.S. counties had at least one health center supported by Title X.[3]

26. In some states and territories, the state or territorial health department is the sole grantee operating the single Title X project for the state or territory; other states or territories have a non-profit organization as the sole grantee; and in other states or territories there may be multiple Title X grantees with multiple projects. Roughly half of Title X grantees are governmental entities and half are non-profit institutions. Some grantees handle only overall program direction, funding, administration, and oversight, while their sub-recipients provide all clinical care at their service sites. In other instances, the grantee itself operates direct service sites and may or may not also have sub-recipients who operate additional sites.

27. In 2017, Title X-funded health centers served 4,004,246 clients.

[3] Special tabulations of data from Jennifer J. Frost, Mia R. Zolna & Lori Fohwirth, *Contraceptive Needs and Services, 2010*, Guttmacher Institute (July 2013), https://www.guttmacher.org/sites/default/files/report_pdf/ contraceptive-needs-2010.pdf.

Women made up 88% of those served, men 12%. Title X programs serve patients without regard to age or marital status. In 2017, approximately 91% of program users were adults; 9% were 18 or 19 years of age, 47% were between 20 and 29, 36% were 30 or older. Title X programs serve a racially and ethnically diverse population, including a disproportionately high percentage of black and Latina clients. According to the 2017 FPAR, 54% of program users identified as white, 22% as black or African-American, 33% identified as Hispanic or Latinx, 4% as Asian, and 1% as either Native Hawaiian or Other Pacific Islander or American Indian or Alaska Native. 2017 FPAR at 10-12. 25. Fourteen percent of 2017 users reported having limited English proficiency. *Id.* at ES-2.

28. Consistent with Title X's purpose, providers in a Title X project must give priority in the provision of services to persons with limited incomes and in fact, Title X clients are overwhelmingly poor or low-income. In 2017, 90% of clients had incomes at or below 250% of the federal poverty level ("FPL"); 67% had incomes at or below poverty the poverty level and 23% had incomes between 101-250% of the FPL. *Id.* at 21. In 2017, the FPL for a single person was $12,060 and $24,600 for a family of four in the 48 contiguous states and District of Columbia.[4] As required by Title X regulation, clients with incomes below the federal poverty line do not pay anything for the services or supplies they receive

[4] Office of the Secretary, U.S. Dep't of Health & Human Services, *Annual Update of the HHS Poverty Guidelines*, 82 Fed. Reg. 8831 (Jan. 31, 2017).

from a Title X provider. For clients with incomes not below the federal poverty line but not more than 250% of that level, Title X providers charge using a schedule of discounts to the reasonable cost of providing services or supplies.

TITLE X CLINICAL STANDARDS AND PROGRAM REQUIREMENTS

29. Each Title X project supplements its federal funding with service reimbursement payments, such as from Medicaid or private insurance, patient-paid fees (from those with incomes between 101 and 250% of the FPL as well as from patients paying full fee for their care), and/or state, local or private sources. These sources, together with Title X funds, comprise the project's overall budget. But the Title X grants are the essential backbone of this national program. That is because the Title X grant requires the critical feature of free care for low-income patients, supports staff and infrastructure expenses that are not reimbursable under insurance, arises out of merit-based selection of grantees, and requires providers to comply with all of the Title X program's comprehensive requirements.

30. All care within any Title X project, even though the Title X grant is only a part of the project's budget, is bound by the federal law, regulations, and clinical and administrative standards of the Title X program.

31. The central OPA office within HHS, which was created by the same legislation that established Title X, administers the overall program. As OPA's current Program Requirements for Title X summarize:

> All Title X-funded projects are required to offer a broad range of acceptable and effective medically (U.S. Food and Drug Administration (FDA)) approved contraceptive methods and related services on a voluntary and confidential basis. Title X services include the delivery of related preventive health services, including patient education and counseling; cervical and breast cancer screening; sexually transmitted disease (STD) and human immunodeficiency virus (HIV) prevention education, testing, and referral; and pregnancy diagnosis and counseling.[5]

The Program Requirements also specify that Title X services are to comply with the national standards of clinical care set forth in the QFP, discussed further below.

32. When a patient comes to a Title X-funded health center, she or he sees and experiences it as a place to gain access to clinical care by medical professionals—just like any other health center or doctor's office.

33. Likewise, the clinical care expected by patients and offered under the terms of Title X is the same type of care that is offered in a private-practice medical office, not second-class care. The confidential, trusting clinician-patient relationship, for example, is at least as important to Title X patients as it is to any other patient populations.

34. In fact, in my experience and based upon my knowledge of the field, Title X patients often have a heightened need to be able to trust, understand, and rely upon the medical professionals that provide them with this safety-net care.

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[5] Office of Population Affairs, *Program Requirements for Title X Funded Family Planning Projects*, at 5 (Apr. 2014), https://www.hhs.gov/opa/sites/default/files/Title-X-2014-Program-Requirements.pdf.

That is because Title X patients often have had a previous negative experience in attempting to navigate the health care system as low-income persons and have fewer personal connections to health care professionals that they can draw upon. They often have no or limited other options for care. Patients often face multiple challenges in receiving appropriate and complete clinical care, such as language barriers, cultural differences, a history of trauma or abuse, and/or other vulnerabilities. And Title X care touches on the most intimate and sensitive areas of life, again requiring a high degree of trust between patient and health care provider to allow the communication that is essential for quality clinical care and education.

35. For all these reasons, Title X patients especially need to be able to count on the professionalism, thoroughness, and sensitivity to patients' concerns from the medical providers they encounter within Title X health centers.

The QFP Clinical Standards

36. Because Title X aims to best advance equal and effective access to family planning methods and services, OPA has periodically adopted and revised clinical standards and other program guidance. These have governed grant applicants and grantees to help ensure that Title X programs are providing evidence-based clinical care consistent with current nationally recognized standards, and are consistently and effectively accomplishing Title X' s purpose.

37. In 2014, the OPA and the Centers for Disease Control issued a joint publication on clinical standards for providing quality family planning services. The QFP describes national clinical guidance for any family planning provider, whether funded by Title X or not.

38. The QFP set new national clinical standards for family planning services, after a lengthy process involving dozens of technical experts and the Expert Working Group of which I was a part. It drew on the CDC's "long-standing history of developing evidence-based recommendations for clinical care" and the fact that "OPA's Title X Family Planning Program has served as the national leader in direct family planning service delivery" since 1970. QFP at 2.

39. The QFP's recommendations "outline how to provide quality family planning services, which include contraceptive services, pregnancy testing and counseling, helping clients achieve pregnancy, basic infertility services, preconception health services, and sexually transmitted disease services." *Id.* at 1. These recommendations, for example, are used by medical directors, including those who oversee Title X projects, "to write clinical protocols that describe how care should be provided." *Id.* at 3.

40. As described in the QFP, chief among the essential attributes of quality care (discussed immediately after safety and effectiveness) is a "[c]lient-centered" approach. *Id.* at 2. Client-centered care means starting from the client's

own reason for seeking family planning information or services. *Id.* at 2, 4. It is also essential that care "is respectful of, and responsive to, individual client preferences, needs, and values" and that individual "client values guide all clinical decisions." *Id.* at 4. Thus, under the QFP standards, providers' own preferences do not determine patient care. Instead, providers are trained and work hard to provide patients in a culturally sensitive and individualized way, with the information and assistance each patient needs to make informed decisions consistent with the patient's own priorities and beliefs—not those of an individual provider.

41. Similarly, QFP appendices that address quality family planning counseling and best practices for providing information to clients stress the fundamental principle that "[e]stablishing and maintaining rapport with a client is vital to" family planning counseling. *Id.* at 45; *see id.* at 48.

42. Further, "[c]lients need information that is medically accurate, balanced, and nonjudgmental to make informed decisions," and the provider "must present information in a manner that can be readily understood and retained by the client." *Id.* at 46. The QFP discusses strategies for making information accessible and clear to clients, to help ensure that each one can understand the options and make informed choices.

43. The QFP specifically instructs, in a section entitled "Pregnancy

Testing and Counseling," that pregnancy "test results should be presented to the client, followed by a discussion of options and appropriate referrals." *Id.*at 14. "Options counseling should be provided in accordance with the recommendations from professional medical associations, such as ACOG [(the American College of Obstetricians and Gynecologists)] and AAP [(the American Academy of Pediatrics)]." *Id.* at 14. It states that "[r]eferral to appropriate providers of follow-up care should be made at the request of the client" and not delayed. *Id.*

44. Similarly, at the National Clinical Training Center for Family Planning, funded by OPA to support Title X-funded providers, one of the 14 designated "core competencies" for family planning care is the ability to "[p]rovide pregnancy testing and counseling and appropriate referrals (to prenatal care, adoption services, and abortion), as needed."[6] The core competency emphasizes that this counseling should be nondirective and include medically accurate discussion about options.

45. The QFP also endorses an approach to contraceptive counseling that emphasizes sharing with patients information about effectiveness of contraceptive choices. It "support[s] offering a full range of Food and Drug Administration (FDA)-approved contraceptive methods," as long as each is safe for the particular

[6] National Clinical Training Center for Family Planning, *Core Competencies for Contraceptive and Other Related Family Planning Services in the Context of Zika*, http://nctcfp.org/Competencies/Core%20Competencies%20in%20English.pdf

patient, "as well as counseling that highlights the effectiveness of contraceptive methods" so that "clients can make a selection based on their individual needs and preferences." QFP at 2, 8. For clients "who have completed childbearing or do not plan to have children," the QFP instructs that "permanent sterilization (female or male) is an option that may be discussed. Women and men should be counseled that these procedures are not intended to be reversible and that other highly effective, reversible methods of contraception (e.g., implants or IUDs) might be an alternative if they are unsure about future childbearing." *Id.* at 9.

46. The QFP standard is to provide equitable, evidence-based care consistent with current professional knowledge, so that family planning does not vary in quality because of the personal characteristics of clients or the personal preferences of providers. *Id.* at 4.

PRIOR FEDERAL HEALTH CARE REFUSAL REGULATION AND LITIGATION

47. In the decades-long history of the federal health care refusal statutes, none of which delegate rulemaking authority to HHS, regulations purporting to clarify and interpret these laws have been promulgated only one other time, in late 2008.

48. At that time, HHS promulgated a notice of proposed rulemaking purporting to interpret and enforce the federal health care refusal statutes claiming "concern . . . that there is a lack of knowledge on the part of States, local

governments, and the health care industry" of the refusal rights contained within these statutes. Proposed Rule, Ensuring that Department of Health and Human Services Funds Do Not Support Coercive of Discriminatory Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 50,274, 50,278 (Aug. 26, 2008)) (hereinafter "2008 NPRM"). Despite allowing only a 30-day comment period, HHS received more than 200,000 comments in response to the proposed rule—the vast majority of which opposed the rule as unnecessary, unauthorized, and overbroad. Notably, HHS conceded in the final rule published December 19, 2008, it received "no Comments indicating that there were any [federal] funding recipients not currently compliant with [the underlying statutes]." Ensuring that Department of Health and Human Services Funds Do Not Support Coercive of Discriminatory Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 78,072, 78,095 (Dec. 19, 2008) (hereinafter "2008 Refusal Rule").

49. The 2008 Refusal Rule would have permitted institutions and individuals employed at federally funded health care entities to refuse to provide a variety of basic health care services, including information, counseling and referrals, while completely ignoring the needs and rights of patients. *Id.* at 78,074. The 2008 Refusal Rule was scheduled to become effective on January 20, 2009—Inauguration Day.

50. On January 15, 2009, NFPRHA filed suit in the U.S. District Court for

the District of Connecticut seeking to enjoin the rule from taking effect (*National Family Planning & Reproductive Health Association, Inc. v. Leavitt*, No. 09-cv-55). The case was consolidated in the same court with similar challenges brought by then-Connecticut Attorney General Richard Blumenthal (on behalf of himself and the Attorneys General of California, Illinois, Massachusetts, New Jersey, New York, Oregon and Rhode Island) and the Planned Parenthood Federation of America and Planned Parenthood of Connecticut.

51. A new notice of proposed rulemaking proposing to rescind the 2008 Refusal Rule was published in the Federal Register on March 10, 2009, with a 30-day comment period. Proposed Rescission of the Regulation Entitled "Ensuring that Department of Health and Human Services Funds Do Not Support Coercive of Discriminatory Policies or Practices in Violation of Federal Law," 74 Fed. Reg. 10,207 (Mar. 10, 2009) (hereinafter "2009 NPRM"). Because rescission had been proposed, the federal lawsuit was put on hold.

52. In 2011, HHS rescinded those aspects of the 2008 Refusal Rule that were "unclear and potentially overbroad in scope," but maintained those parts of the rule establishing an enforcement process for the federal health care refusal statutes and began an "initiative designed to increase the awareness of health care providers about the protections provided by the health care provider conscience statutes, and the resources available to providers who believe their rights have been

violated." Regulation for the Enforcement of Federal Health Care Provider Conscience Protections, 76 Fed. Reg. 9968, 9969 (Feb. 23, 2011) (hereinafter "2011 Rule"). This rule remains in effect.

THE 2019 HEALTH CARE REFUSAL RULE CONFLICTS WITH TITLE X'S COMMITMENT TO CLIENT-CENTERED CARE AND WILL HARM TITLE X PATIENTS

The Health Care Refusal Rule Will Authorize Employees With Religious or Moral Objections to Categorically Refuse to Provide Required Title X Services Despite the Harm It Would Cause to Patients or the Employer

53. As I understand it, the Health Care Refusal Rule includes expansive definitions that dramatically expand the scope, meaning, and impact of the underlying statutory refusal provisions, permitting numerous individuals—in Title X-funded settings and despite Title X requirements or client needs and wishes—to refuse to perform or take any "action that has a specific, reasonable, and articulable connection to furthering a procedure or a part of a health service program" administered by HHS (like Title X).

54. The Rule's expansive definitions of "assist in the performance" and "referral" and "refer for" would permit employees of Title X-funded health centers and other federally funded entities to refuse to provide certain reproductive health information and referrals, despite patient needs and in clear violation of the fundamental tenets of informed consent, ethics, and the Title X program requirements, including those found in the regulations, the statute, and the QFP.

55. As I understand it, the Rule also makes dramatic changes to the existing statutory understanding of "discriminate" or "discrimination," requiring an absolute accommodation by employers of their employees' religious and/or moral objections to performing or assisting in the performance of sterilization or abortion (including counseling and referral) and rejecting the longstanding balancing approach of Title VII of the Civil Rights Act that provided employers with the ability to manage religious accommodations for employees in a manner that balances the religious beliefs of the employee with the business operation needs of the employer.

56. The Rule also prohibits employers from asking job applicants whether they have any such objections to performing these aspects of the job. In fact, HHS explicitly refused to address in the Rule whether an employer under the Rule would be allowed to disqualify a person with religious or moral objections to covered practices even if such covered practices made up the primary or substantial majority of the duties of the position. However, HHS also stated in the Rule's preamble that it is "not an acceptable practice under Federal conscience and anti-discrimination laws for covered entities to deem persons with religious or moral objections to covered practices, such as abortion, to be disqualified for certain job positions on that basis." 84 Fed. Reg. at 23,191. As such, the rule puts Title X-funded health centers in the position of being forced to hire people who

intend to refuse to perform essential elements of a position.

57. Thus, "discrimination" under the Rule would seem to prohibit a Title X-funded entity from even asking a person applying for a job as a counselor or clinician whose essential job functions would include counseling women with positive pregnancy tests whether the individual would refuse to provide non-directive options counseling, let alone not hire the applicant because of such objections. And, once hired, the Title X-funded entity would be required to accommodate that objection without regard to the burden placed on the employer or the impact on patients.

58. Indeed, the Rule provides no meaningful guidance on how an employer is supposed to ensure patients continue to receive care in the face of an employee's objection to performing a core job function and still comply with the Rule. For example, the Rule states that "the voluntary acceptance of an effective accommodation of protected conduct, religious beliefs, or moral convictions, will not, by itself, constitute discrimination." The rule further states that "staffing arrangements," such as "non-retaliatory staff rotations," *can* be "acceptable accommodations in certain circumstances." *Id.* But these vague platitudes provide cold comfort to the employer trying to determine how to balance patient health and safety and comply with Title X's requirements and ensure that patients are receiving the care to which they are entitled by law, on a limited budget, without

risking the loss of critical federal funding.

59. This difficulty will be especially acute in Title X-funded settings without many employees, located in sparsely populated or rural areas, and in the 649 counties where a Title X-funded health center is the only publicly funded family planning provider.[7] For example, one Title X grantee in a rural state has only three nurse practitioners for its more than 10 health centers; these clinicians travel from health center to health center, meaning that only one would be at any one service site only a few days per month. If one (or more) of those clinicians objected to providing certain services, it would make it incredibly difficult for the health center or grantee to ensure that its patients continue to receive that care.

60. Title X-funded family planning organizations typically have deep expertise in the care they provide, and are trusted in their communities to provide high-quality, confidential, voluntary care to their clients. However, to the extent the Rule forces Title X providers to hire and employ individuals who actively withhold information and services from clients, the Rule will harm the providers' reputations and the provider-patient relationship of trust.

[7] Jennifer J. Frost et al., *Publicly Funded Contraceptive Services at U.S. Clinics, 2015,* Guttmacher Institute, (Apr. 2017), https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015.

The Health Care Refusal Rule Will Also Harm Title X Patients By Allowing into the Title X Network Employees and Entities That Refuse to Provide Required and Critical Title X Health Care Services

61. In many respects, the Health Care Refusal Rule is an attempt by HHS to achieve by a back door what courts have already blocked: remaking Title X's network of providers in order to replace high-quality, trusted providers with new participants who object to core Title X care and use their religious beliefs to limit patients' access to complete and accurate reproductive health information, displacing the primacy of a patient's own beliefs or needs.

62. In the arena of health care, and particularly family planning and sexual health, HHS-funded programs cannot achieve their fundamental, statutory objectives if grantees, providers, and contractors have a categorical right to refuse to provide essential services, such as non-directive pregnancy options counseling.

63. As I understand it, for state and local health departments (NFPRHA represents 80% of health department Title X grantees) the Rule's definitional expansion of discrimination would also put health department grantees and sub-recipients in the untenable position of being forced to subcontract with entities without knowing (or even being able to ask) whether an entity objects to providing essential aspects of the Title X project.

64. As such, the Health Care Refusal Rule seems designed to allow entities that refuse to provide people seeking Title X health care with the basic

information, options counseling, and referrals required by law to compete on the same footing for federal money with family planning providers that adhere to the law and provide full and accurate information and services to patients. The Rule thus threatens to divert scarce family planning resources away from entities that provide comprehensive family planning services to organizations that refuse to provide these services. Diverting funds away from providers offering the full range of family planning and sexual health services would not only seriously undermine public health, especially for the low-income, uninsured, and under-insured, but would also be contrary to congressional intent and explicit statutory requirements of the Title X family planning program.

65. The Health Care Refusal Rule is HHS's third attempt to drastically change the Title X network in the last two years and reshape it contrary to the program's intent.

66. Traditionally, Title X grant competitions are run each year, and over a three-year period, all the grants are newly competed and awarded. The 2018 Funding Opportunity Announcement ("FOA"), which was unprecedented in that all jurisdictions were competed in a single year, drastically altered the criteria for evaluating grant applications. In particular, these changes deemphasized and devalued the provision of core Title X services—including nondirective pregnancy options counseling and abortion referrals—so that providers with objections to

performing those core services could still compete in the program. Fortunately, even with the relaxed criteria, HHS did not receive sufficient, adequate applications from those opposed to abortion counseling and referrals to fundamentally alter the network in the way it intended.

67. However, when that attempt to remake the network through the grant-making process failed, on June 1, 2018, HHS published a notice of proposed rulemaking for the Title X family planning program ("2018 Title X NPRM"). The 2018 Title X NPRM not only reintroduced the majority of a Reagan-era Title X rule known as the "domestic gag" rule, but it expanded those provisions and introduced numerous new and harmful requirements and restrictions.

68. The final rule was published on March 4, 2019. *See* Compliance with Statutory Program Integrity Requirements, 84 Fed. Reg. 7714 (Mar. 4, 2019) (hereinafter "2019 Title X Rule"). Among other provisions, the 2019 Title X Rule violated various federal laws by restricting the ability of *all* Title X providers to provide abortion referrals and allowing providers to exclude the option of abortion from pregnancy counseling, even when the patient specifically seeks information about abortion.

69. NFPRHA filed a challenge, along with three co-plaintiffs and in conjunction with a related case filed by the Attorney General of Washington, to the 2019 Title X Rule, seeking to enjoin and set aside the unlawful rulemaking before

the rule's effective date of May 3, 2019. On April 25, the U.S. District Court for the Eastern District of Washington issued a preliminary injunction enjoining HHS from implementing or enforcing any part of the 2019 Title X Rule. *See Washington v. Azar*, 376 F. Supp. 3d 1119 (E.D. Wash. 2019).

70. In effect, the Health Care Refusal Rule is an attempt to accomplish via the back door—the dismantling of these core elements of the Title X program—what HHS has been unable to and prevented from directly accomplishing by other means.

The Refusal Rule's Compliance and Enforcement Mechanisms Are Ripe For Abuse, Will Create Significant Compliance Burdens, and Will Jeopardize The Future of the Title X Program

71. In addition to the harms I describe above, I am very concerned that the Rule's new compliance and enforcement mechanisms will threaten the critical funding our members rely on to provide essential health care services.

72. For example, the Rule would allow the Office for Civil Rights to investigate any Title X-funded entity whenever any information—even a third-party complaint or a news report—"indicates a threatened, potential, or actual failure to comply with Federal conscience and anti-discrimination laws" or the Rule.

73. The Rule also requires covered entities to at all times maintain records "evidencing compliance" and explicitly states that covered entities must provide

the Department virtually unlimited access to its books, records, accounts, facilities, and information upon request, and without regard for privacy or confidentiality concerns.

74. If HHS determines that an entity—or one of its sub-recipients—is out of compliance with the Rule, HHS can withhold, deny, suspend, terminate, or clawback billions of dollars in federal funds, including non-HHS appropriated or administered funds. HHS can even terminate federal funding during the pendency of good-faith voluntary compliance efforts.

75. Moreover, given the Rule's permitting broad investigations based on potentially biased, agenda-driven complaints and the significant penalties under the Rule—including the requirement to report violations for a three-year period in any future grant applications—entities that receive HHS funds (including NFPRHA members) face significant concern about how collected information is intended to be used and whether it and/or any violations will unfairly prejudice consideration of applicants for federal funds or penalize currently funded entities in ways that could be extremely harmful.

76. Any loss of Title X funds would have a direct impact on NFPRHA members' functions: cuts in health centers' hours; staff layoffs; and, in some cases, health center closures. This would mean fewer patients would receive much-needed contraceptive and preventive services, as NFPRHA members are often low-

income patients' only option.

77. Indeed, six in ten Title X patients reported that the Title X-funded health center constituted their only source of health care over the past year.[8] Fourteen percent of all women and 25% of all poor women who obtained contraceptive services did so at a Title X-funded health center.[9] Ten percent of women who received a Pap test or pelvic exam, 18% of women who received testing, treatment, or counseling for a sexually transmitted infection (STI), and 14% of women tested for HIV during that time period received that care at a Title X-funded health center.[10]

78. Thus, loss of Title X-funded care—whether through reduced hours, staff layoffs, or closures—or directly through the provider refusals permitted by the Health Care Refusal Rule—will cause NFPRHA members' patients to suffer not only diminished access to family planning care, but also a range of other preventative care. The Health Care Refusal Rule would force NFPRHA members' patients to lose access to standard, ethical pregnancy counseling and referrals for abortion care, and would leave NFPRHA's members with few, if any, options to "use alternate staff or methods to provide or further any objected-to conduct"

[8] Megan L. Kavanaugh, Mia R. Zolna & Kristen Burke, *Use of Health Insurance Among Clients Seeking Contraceptive Services at Title X-Funded Facilities in 2016*, 50 Perspectives on Sexual & Reproductive Health 101 (Sept. 2018) https://www.guttmacher.org/journals/psrh/2018/06/use-health-insurance-among-clients-seeking-contraceptive-services-title-x.

[9] *Id.*

[10] *Id.*

without risking it being considered "adverse treatment" against the objecting employee or sub-recipient.

79. If HHS succeeds in bringing religious objectors into the Title X network, patients will also encounter more sites with other limitations, including only one or a few contraception options and no information about a broader range of methods, further undermining the program. All of these impacts will expose patients to greater health risks and more unintended pregnancies. The Health Care Refusal Rule will harm the central purpose of Title X and sacrifice low-income patients' care to these new mandates.

80. Given the consequences are so severe, the cost-burdens associated with complying with the Rule—including obtaining legal advice to assess and advise on compliance, including the Rule's interaction with existing state and federal legal obligations; reviewing and potentially revising job descriptions, hiring practices, and employee recruitment materials; revising policies and procedures, manuals, and handbooks; re-training staff with supervisory responsibilities on hiring and accommodation requests; and, of course, the cost of providing accommodations under the Rule and providing, if possible, alternate means for patients to receive the objected-to care—are significant.

81. Yet HHS grossly underestimates what compliance will entail. For example, the Rule estimates that covered entities will spend: (1) two hours on

average familiarizing themselves with the rule and its requirements, which represents the "one-time opportunity cost of staff time (a lawyer) to review the rule"; and (2) "an average of 4 hours [per year for the first five years] reviewing the assurance and certification language and the Federal conscience protection and associated anti-discrimination laws and the rule," which is "a function of a lawyer spending 3 hours reviewing the assurance and certification and an executive spending one hour to review and sign." 84 Fed. Reg. at 23,240-41.

82. Based on my knowledge and expertise of how seriously our members take their legal and ethical obligations, and based on my own review of the Rule (which runs over 100 pages) and the underlying laws, I believe this estimate totally misjudges the costs simply attempting to come into compliance with the Rule will impose on our members. For example, when the QFP standards were put in place in 2014, it took many grantees a year or more to update all policies and protocols, revise materials and have those materials reviewed by outreach and education committees (a process required under Title X guidelines), and sufficiently train staff at all service sites on the new clinical standards.

* * *

83. In conclusion, based on my knowledge and experience, it is my firm belief that if this Rule takes effect it will have a devastating impact on our members, the patients they serve, and the Title X program as a whole.

I declare under penalty of perjury that the foregoing is true and correct. This declaration was executed on June 13, 2019, in Washington, D.C.

Clare M. Coleman

EXHIBIT E

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION; and PUBLIC HEALTH SOLUTIONS, Plaintiffs, v. ALEX M. AZAR II, in his official capacity as Secretary of the U.S. Department of Health and Human Services; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROGER SEVERINO, in his official capacity as Director of the Office for Civil Rights of the U.S. Department of Health and Human Services; OFFICE FOR CIVIL RIGHTS of the U.S. Department of Health and Human Services, Defendants.	Civil Action No.: 1:19-cv-05435 (rel: 1:19-cv-04676-PAE; 1:19-cv-05433-PAE)

DECLARATION OF LISA DAVID

Lisa David declares and states as follows:

1. I am the President and Chief Executive Officer at Public Health Solutions ("PHS"). PHS is a not-for-profit corporation organized under the laws of New York, headquartered at 40 Worth St, New York, NY 10013. I have been the President and Chief Executive Officer of PHS since 2015.

2. I have more than three decades experience working in the health services field, including in the areas of hospital administration and direct services management. At PHS and throughout my career, I have been responsible for managing nonprofit public health care institutions' budgets, compliance and quality management, recruitment, and general operations.

I work closely with PHS's Program Directors to track, assess, and strategize ways to improve the performance of our programing, as well as managing our finances.

3. PHS was first established in 1957 and is currently the largest public health nonprofit serving New York City. PHS was originally created as part of the New York City Department of Health and Mental Hygiene ("DOHMH"), and though we are no longer part of a city agency, we continue to have a robust, long-standing partnership with the New York City and State governments. Our work reaches clients in all five boroughs, as well as in Nassau, Suffolk, Putnam, Westchester, and Rockland Counties. Notably, our sexual and reproductive health centers have been providing comprehensive, community-based family planning services (and related health care) to Brooklyn for over 50 years, resulting in a stable and trusted presence in their communities.

4. As an organization, PHS is dedicated to developing, implementing, and advocating for dynamic solutions to prevent disease and improve community health. PHS has been a leader in addressing crucial public health issues, including food and nutrition, health insurance access, maternal and child health, reproductive health, tobacco control, and HIV/AIDS prevention. Our programs have a strong focus on health disparities to ensure New York City families have the basics for a healthier life. As a Title X grantee, we are also a proud member of Plaintiff National Family Planning and Reproductive Health Association.

5. PHS employs approximately 415 individuals, including full-time staff, part-time staff, and contract workers. In addition, interns, volunteers, and contractors support us in caring for our clients and their communities.

6. I have read the Department of Health and Human Services' ("HHS") final rule (the "Rule") at issue in this case and understand that, unless it is blocked by a court, it will take

effect on July 22, 2019. Because I believe the Rule will immediately impede our efforts to achieve our goals, jeopardize the health and well-being of our patients, and will harm PHS's longstanding reputation in the community as a trusted provider of patient-centered, compassionate, high-quality health care, I submit this declaration in support of Plaintiffs' Motion for a Preliminary Injunction.

PHS'S FEDERAL FUNDS AT RISK BY THE RULE

7. Federal funds account for almost all of the money that PHS uses to provide family planning services either directly or through agencies with which it contracts.

8. PHS is New York City's largest grantee for the Title X[1] program—the federal government's only funding stream dedicated exclusively to family planning services—and has successfully competed for Title X grant funds for 36 years. PHS was most recently awarded a $4.6 million Title X grant, approximately 86% of which ($3.9 million) is dispersed to five delegate agencies (known as "sub-recipients"), as well as PHS's own two sexual and reproductive health centers, to provide family planning services to low-income and uninsured New Yorkers. PHS is also a sub-recipient of the New York State Department of Health's ("DOH") Title X grant, through which it receives additional Title X funding for its two health centers.

9. PHS and its sub-recipients rely on Title X funding to deliver family planning services. Title X funding constitutes approximately two-thirds of PHS's total family planning program revenue. This funding supports the provision of comprehensive sexual and reproductive health services, including clinical and support staff salaries and maintaining the health centers, as well as the procurement of contraceptives to increase same-day access to

[1] Title X refers to Title X of the Public Health Services Act ("PHSA"). 42 U.S.C. § 300(a).

methods that are more expensive for health centers to routinely stock, such as long-acting reversible contraceptives.

10. PHS and its sub-recipients are also reimbursed through the federal Medicaid program for services provided to eligible patients, including for family planning services and prenatal care. Medicaid reimbursement comprises 99% of PHS's non-grant patient service revenue.

11. PHS is the lead agency for the Healthy Start Program, an HHS project funded under the PHSA, which is a partnership through which pregnant people and children up to age two are referred for services to strengthen family resilience.

12. PHS receives over $25 million in grant funding from HHS for the Hospital Preparedness Program and Public Health Emergency Preparedness Cooperative Agreements. Through these programs, PHS supports hospitals and community-based organizations in developing and maintaining disaster plans for public health emergencies.

13. As a longstanding partner with the New York City government, PHS is also the administrator for a substantial amount of federal grant funding that the City receives, meaning PHS is responsible for re-granting that funding to other organizations. PHS administers the NYC DOHMH's $140 million grant from the Centers for Disease Control and Prevention to do HIV prevention work, as well as to train people to do that work. PHS is also the administrator for $125 million in grant funding from the Ryan White HIV/AIDS Program administered by HHS, which PHS re-grants on behalf of the NYC DOHMH as well as Rockland, Putnam, and Westchester Counties. Administering these grants strengthens PHS's already deep roots in the community through its work with over 200 local community organizations that receive the funding.

14. In total, PHS receives $182 million in funds that originate from the federal government—$138 million of which originates from HHS, with PHS receiving $31.4 million of those funds directly from HHS—all of which could be at risk if PHS is found to be out of compliance with the Rule.

15. As President and Chief Executive Officer, I am responsible for ensuring that our clinical locations and sub-recipients provide their clients with the full range of services required by the federal law governing these funding streams. For example, the Title X program requires PHS and its sub-recipients to provide clients with a broad range of effective, medically-approved family planning methods and services (such as comprehensive reproductive health exams, STD and HIV testing and treatment, and pregnancy testing); to provide services while respecting our clients dignity, and without subjecting them to any coercion; and to offer non-directive options counseling to pregnant people, including regarding prenatal care and delivery, infant care, adoption, and abortion. All PHS and sub-recipient facilities offer a broad range of medically approved family planning methods either on site or by referral.

16. Additionally, I am responsible for ensuring, along with PHS's Program Directors, that our services are meeting all applicable standards of care, including ensuring that patients provide informed consent. The AMA's Code of Medical Ethics explains that patients have a right to make voluntary, well-considered decisions about their care, and so health care providers must inform their patients about all relevant options for treatment in order to abide by the principles of informed consent.

17. To ensure compliance with state and federal standards and guidelines, PHS puts its sub-recipients through a rigorous application process. In addition, PHS employs an extensive quality-monitoring program for both its own sites and its sub-recipients. PHS conducts a

comprehensive monthly review of its own health centers' quality data, and reviews reports from sub-recipients on a quarterly basis, in addition to regular monitoring visits, internal reviews of policies and procedures, and interviews of staff and clients. We also closely monitor, investigate, and respond to all clients' complaints.

PHS'S HEALTH SERVICES

18. PHS addresses critical public health issues through a client-centered approach, which is at the core of our mission. In 2018, PHS served 105,000 individuals and families across New York City through our various direct services programs.

19. The services offered by our centers include: affordable, comprehensive, and confidential reproductive healthcare for adults and adolescents; services to support pregnant and parenting families, including one-on-one health care and education in the home as well as group support during pregnancy and early childhood; health insurance enrollment; and food benefits assistance, among other innovative public health programs and initiatives. Part of PHS's strength is our demonstrated ability to cross-refer clients to other PHS programs for a continuum of critical services, and to that end, some of the programs are even located together. For example, our sexual and reproductive health centers have on-site health insurance enrollment services, and frequently refer patients to our home-visit health care programs. Our Neighborhood Women Infants and Children ("WIC") program centers regularly refer clients to our programs for health insurance enrollment and food benefits assistance, both of which are located at the same site.

20. With respect to reproductive health care, PHS and its sub-recipients provide prenatal and family planning services to over 40,000 at-risk patients annually throughout New York City. As noted above, in addition to the provision of most available birth control methods

on-site (including long-acting reversible contraceptives and emergency contraception), Title X-funded services at our two health centers include free walk-in pregnancy testing; gynecological exams; men's sexual healthcare; teens' sexual healthcare; STD and HIV testing, treatment, and counseling; mental health services; and health education. We also provide additional services at our health centers, such as prenatal care and HIV prevention through HIV Pre-Exposure Prophylaxis, with non-Title X funds.

21. At all of our health centers, patients with a positive pregnancy test who receive counseling are offered neutral, nondirective counseling on all pregnancy options—including adoption, continuation of the pregnancy, and abortion—and referrals for medical care outside of the program are made as requested. This is not only required by federal law, but fundamental principles of medical ethics and informed consent. All counseling is provided in a patient-centered approach and is guided by the specific needs, values, and requests of the patients.

22. Our client population for family planning services is diverse: We see people of all races and ethnic groups. In 2017, 40% of PHS's Title X clients identified as Black or African American, compared to 26% of New York City's population, while 42% identified as Hispanic or Latino/a, compared to 29% of the City's population. We serve teenagers and adults; people who have children, or plan for children, or do not want to be parents. Our patients are married and unmarried; lesbian, gay, bisexual, transgender, and queer ("LGBTQ") individuals; and a significant portion are immigrants. A total of 15% of the clients had limited English proficiency.

23. We serve predominantly low-income, high-risk patients who are dependent on publicly subsidized health facilities to obtain basic—but critical—medical care. Approximately 70% of PHS patients are 100% below the poverty level, 76% are 200% below the poverty level,

and 26% lack health insurance.[2] Nearly all of our patients rely on Medicaid. The overwhelming majority of our family planning patients reside in medically underserved areas where reproductive health services are not easily accessed. Without publicly funded health care, our patients would likely receive no preventative care at all.

24. I know from my experience in the family planning field that the availability of pregnancy counseling, including information and referrals for abortion, is essential to the ability of our patients and their families to take control of their lives and do the best they can to create the futures they want for themselves and their children. Some of our clients tell us that they are doing everything possible to provide for their children and know that they cannot afford to expand their families. Other clients share that they are working their way through college or have just secured employment and that early parenthood (or another child) would derail their plans for education or work. We care for clients who are in abusive relationships for whom pregnancy can put them at grave risk both because abuse often increases during pregnancy and because having a child makes it much more difficult for a person to eventually escape from an abusive relationship. For these patients, access to contraception and abortion can be a matter of survival. For our clients who have recently given birth, it is important for their own health and for healthy birth outcomes that they not become pregnant again until their bodies have recovered. Finally, some of our clients do not want children, but without birth control and referrals to abortion care, they are unable to exercise autonomy and self-determination. For all of these clients, and others, the family planning services we provide are critical.

[2] In 2019, the FPL for a single person is $12,490 and $ 25,750 for a family of four in the 48 contiguous states and District of Columbia. HHS, Office of the Secretary, *Annual Update of the HHS Poverty Guidelines*, 84 FR 1167 (February 1, 2019). In 2019, 200% of the FPL for a single person in the 48 contiguous states and District of Columbia was $24,980 per year, and $51,500 for a family of four.

THE RULE WILL INFLICT IMMEDIATE AND IRREPARALE HARM ON PHS AND ITS PATIENTS

25. I am very concerned that if the Rule takes effect, it will immediately prevent us from ensuring that our patients continue to receive the services they need in a safe, timely fashion—or at all. In addition, I fear that because the Rule prevents us from guaranteeing that our patients continue to receive the services we are obligated by federal law to provide, we may be forced to reduce or discontinue these essential reproductive health services.

26. Moreover, while PHS has always, to the best of my knowledge, complied with *all* federal laws and guidelines, I am very concerned that, because the Rule is in places vague and in other places appears to be inconsistent with existing legal requirements, the Rule places PHS at serious risk of losing its $138 million in federal funds administered by HHS. And, as I explain further below, if PHS lost its federal funding it would be devastating; we would have to close the doors on our two sexual and reproductive health centers instantly, leaving our patients to try to find other health care providers that provide free or low-cost high quality care. At a minimum, the health centers' 38 employees would be laid off. Additionally, losing our funding stream would impact our sub-recipients, putting their programing, employees, and clients at risk as well.

The Rule's Impact on PHS's Healthcare Delivery Model

27. It is critical to PHS's philosophy of care that we deliver all of our services in a compassionate and nonjudgmental way. For this reason, we work hard to recruit and hire people who are qualified and willing to provide the full range of services to all of our clients. During the hiring process, we inform all applicants of the nature of PHS's work, making sure to describe all of our programs and scope of services, including that we provide emergency contraception as well as counseling and referral for abortion care. We explain that we offer the same, comprehensive, high quality care to all patients, including to LGBTQ individuals, clients who

are sexually active outside of marriage, and to other members of our diverse client base.

28. No matter what specific position applicants have applied for within our health services programs, we ask whether they are willing and able to participate in providing all of our services to all of our clients. We do that because our employees of necessity work as a team, performing work beyond the specifics of their more individualized position titles. Experience teaches that clients rarely compartmentalize their lives to match our different program areas, but rather have a variety of interconnected needs. For example, a client who comes to our maternal and child health programs might reveal that she is pregnant and wants an abortion. Or an adolescent seeking sexual health education might reveal that he is in a same-sex relationship and wants testing and preventative treatment for HIV.

29. Over the years we have identified numerous job applicants who, once they learned more about PHS, have said that they would not be able to provide all of our services in a non-judgmental manner as required by the job, or would not be able to care for one or more of the populations we serve. PHS does not make decisions about job applicants based on their personal beliefs or presume that applicants of any given religious background would be less qualified or unwilling to perform a job at PHS. Rather, PHS relies on the applicants' self-identified limitations in their ability and willingness to perform all required aspects of the job.

30. However, the Rule completely eliminates our ability to strike the appropriate balance between individual staff member's objections and our patients' needs. For example, as I understand it, the Rule prohibits us from even asking job applicants whether they are willing to provide information about and referrals for abortion to patients who request it, or take any other action that has a "specific, reasonable, and articulable connection" to "furthering" an abortion. Yet PHS fills several positions each year for health care providers who conduct home visits, and

about six sexual and reproductive health providers (including doctors, nurses, social workers, and health educators). This does not even include hiring for other administrative staff positions that do not directly provide medical care or counseling, but who work with clinical staff to assist the provision of medical care and counseling.

31. Given that, under the Rule, the requirement to accommodate existing employees' refusals to provide certain care appears absolute, PHS would want to be even more careful about whom it hires when replacing existing positions—particularly nurses and social workers—but the Rule expressly forbids this. For example, there is a current opening for a nurse in one of our home health programs. PHS staff are currently reviewing applications for the position, and at this stage in the process, are assessing whether applicants are comfortable with providing all services required as part of our home-visiting model. If the Rule goes into effect, we will need to make changes to our hiring procedures in the middle of the process, resulting in delays in filling the position and uncertainty as to whether the candidates will provide the broad range of care required by the program. What if a patient reveals to this nurse during a home visit that she had unprotected sex and wants a pregnancy test and to discuss her options? When clients trust their PHS provider enough to reveal these confidences, we know that we are doing our job. Therefore, all of our employees must be able to connect clients to the services they need, whether by providing them with emergency contraception or pregnancy options counseling, or referring them for testing for STDs or for abortion care. It would turn our healthcare delivery model on its head if, following the client's disclosure, the PHS nurse refused to provide the care, information, counseling, or referrals the client needed. Not only would we not be providing the client with what they require, we would be passing judgment on them, thereby shutting down future communication between the client and our staff—if that client returns to us for care at all. Thus,

if the Rule takes effect, I am extremely concerned that PHS will now have no way of knowing if we have hired a candidate who would not help a client needing non-directive pregnancy options counseling or reproductive family planning, even though that is a key component of our service to those clients.

32. Of course, when objections to participating or assisting in the participation of any health care service do arise we have always strived to accommodate our staff members' objections. But our success in doing so has turned on having the flexibility to balance the needs of our patients with the individual beliefs of our staff. Where possible we have transferred duties, re-assigned staff, or otherwise accommodated the staff member's objection.

33. But under the Rule, we can only ask an employee if they object to performing one of their core job functions *after* we have hired them—and even then we can only ask once a year, unless there is persuasive justification to do so more often, but the Rule does not explain what meets that threshold. The employee, however, is under no obligation to inform us of any objections at any time. It could be weeks or months, if at all, before we ever find out that one of our employees is withholding care from our patients. From PHS's point of view, any amount of time where patients are not receiving complete counseling and evidence-based care is too long; when questions about abortion or other treatment do arise, it is at the very heart of our mission to provide comprehensive and accurate information in a non-judgmental manner. Our reputation depends on our non-judgmental approach and we believe it's why our clients stay with us for years and years and refer their friends and family to us as well.

34. Moreover, assuming we are aware of any such objections, the Rule appears to impose on PHS a categorical obligation to accommodate any employee's objection to, for instance, providing information or referrals relating to abortion or sterilization, even in an

emergency, regardless of the impact on patient and public health. In particular, I understand the Rule would eliminate any flexibility we once had to transfer duties or reassign staff. Our only option under the Rule would be to offer the objecting employee a "voluntarily acceptable" accommodation, whatever that may be.

35. I know for a fact that the total lack of flexibility under the Rule could be a problem at some of our clinical locations. For example, it is my understanding that before I started at PHS, our health centers were providing medication abortion for a period of time, and some of the nurses objected to being involved in the service. However, PHS staff were able to have conversations with those nurses about their concerns, conduct trainings to educate staff about medication abortion, and limit the provision of medication abortion to clinicians who did not object to medication abortion. Under the Rule, it is unclear whether it would be permissible for us to take any or all of these actions. Would the discussions and training with staff be considered "retaliation" or an "adverse action"? We have no way of knowing, and yet the consequences of being found to be out of compliance with the Rule could be devastating.

36. Currently, we employ only five medical providers (one doctor, three nurse practitioners, and one certified nurse midwife), three licensed practical nurses, and two social workers who are expected to cycle through our two clinical health centers in Brooklyn. The center in the Eastern Parkway neighborhood of Brooklyn has, at times, only one medical provider on hand to treat patients. Thus, if the medical providers, nurses, or social workers at any of these sites refused to provide non-directive options counseling, including information about abortion, we could not continue to provide these services.

37. This is so for several reasons. First, we do not have the funding to hire any additional staff at these sites. Each of our grant programs is very restrictive in how the funding

can be used, so the funds are not fungible across programs (and that assumes there would be a surplus that could be used to subsidize another program, when in fact our grant funding already does not cover the full cost of providing services). Second, we do not have another program that employs doctors, so we could not simply reassign them (putting aside whether that would constitute discrimination under the Rule). Third, we are required by both state and federal law to provide options counseling and referrals for abortion to all our patients, so, based on our funding and staffing limitations, there is no role at the health centers that would allow a clinician to avoid mention of abortion entirely. We practice non-judgmental and non-coercive counseling to satisfy our ethical obligations and good medical practices as health care providers. Such counseling should be based on the requests and situation of the patient, otherwise it risks imposing the provider's values on patients and undermining provider-patient relationships.

38. Nor could we transfer a client from staff person to staff person in the middle of a counseling session. For example, if a staff person were willing to discuss two but not all three pregnancy options with a client—that is, if a counselor were willing to discuss with a pregnant client her option to carry the pregnancy to term and raise a child and her option to carry the pregnancy to term and place the baby for adoption, but were not willing to discuss the abortion option—we could not simply transfer that client to another staff member to learn about abortion after she heard the first two options. In a program such as the Healthy Start Program that would be completely unworkable, because providers are visiting patients in their home, so there is no one else available to continue counseling. And assigning the client to a new provider would undermine the efficacy of the program, which is intended to create continuity in health care providers for patients who otherwise endure multiple clinical transitions from their pregnancies, to giving birth, to postpartum and pediatric care. As an administrative matter, in a health center

setting, this would interfere with client flow, inconvenience other clients, and lengthen office visits for clients who already have limited time. Further, our health centers accept walk-in clients, so it would be impossible to predict in advance what services will be needed on a given shift—and even when patients have scheduled appointments, they may ultimately request other treatment, counseling, or referrals about different services.

39. But more importantly, transferring clients to a different staff person sends a not-so-subtle message to the client that the PHS counselor is making a judgment about the abortion option and cannot even discuss it. This is contrary to our non-judgmental approach and unacceptable. Participation in our programs is voluntary, and disruption in the patient-provider relationship through the denial of a counseling request could not only disrupt the candor in the relationship, but could end the patient's participation in the program, leading to negative health outcomes for them and their families. I have no doubt that an interaction during a nurse's home-visit appointment that leaves the patient without access to the abortion she needs, and with a feeling that her PHS provider judged her for wanting an abortion, will be the end of that client relationship. And many of our clients learn about us through word-of-mouth—we do minimal marketing or advertising—so if trust in PHS is compromised, needy clients will simply not come to PHS for any of their other health and social services needs, and ultimately, they will not get the care they (and their young children) need, which would have broader public health consequences as well, including an increase in sexual transmitted infections, undetected cancers, and unwanted pregnancies, among other effects.

40. Additionally, arranging to transfer patients assumes that we will know about the staff person's objection and could plan accordingly, but the Rule does not ensure that we are aware of what services our staff will refuse to provide. As described above, I am gravely

concerned that, under the Rule, we may not even know if one of our staff members are withholding information or services from their patients, putting us at risk of violating our legal and ethical obligations, and risking our patients access to the critical, often life-altering, care they need and to which they are entitled.

41. This concern is not limited to counseling regarding abortion services, but extends to other PHS health services and counseling. Many of our health care providers work with patients to develop their long-term reproductive life plan, which sometimes includes counseling, referring for, and coordinating access to permanent forms of contraception through sterilization. Moreover, PHS is ahead of the curve in targeting high-risk populations, to ensure that those living with HIV/AIDS are connected with high-quality care, including LGBTQ individuals. However, given the Rule's broad definitions and confusing requirements, it is foreseeable that some providers will invoke the Rule to refuse basic care to patients simply because of their gender identity or sexual orientation.

42. Our sub-recipients' facilities will face the same challenges. Although we have a rigorous application and screening process, sub-recipients that already receive qualifying federal funds would be subject to the same restrictions we are under the Rule, and would be unable to confirm whether staff will request an accommodation and then refuse to provide the services. Likewise, once a sub-recipient is accepted to our grant programs, they are subject to the same accommodations requirements, potentially preventing us from fulfilling our grant obligations to the detriment of our patients.

43. The ramifications of violating the Rule are particularly expansive, because my understanding is that PHS can be held liable for violating the Rule if one of our sub-recipients violates the Rule. That means that all of PHS's federal funding could be put in jeopardy due to

the actions of a sub-recipient. And because PHS is a Title X sub-recipient for New York, should PHS violate the Rule, that would put all of the state of New York's federal funding at risk as well—thereby endangering all of their other sub-recipients' funding.

The Administrative Costs of the Rule

44. In addition to the costs to our patients and the public health, the Rule imposes significant and immediate costs on PHS.

45. I am aware that HHS estimates that the Rule will impose only minimal costs on each organization subject to its requirements. This is totally untrue. If the Rule is not blocked from taking effect, PHS would have to retain outside counsel to advise us and our Board of Directors. We would need to, with the assistance of legal counsel, review and revise our hiring and employment practices, policies, and forms, and our employee handbooks accordingly. This could be extraordinarily complicated not only because of the Rule itself, but also because many of our employees are covered by a union contract and the interaction between the union contract and the Rule will require additional time and resources to fully understand.

46. Once our new policies and practices are in place, we would have to hold trainings for our staff and our sub-recipients to educate them about our new policies and procedures, to the best of our understanding. Compliance with the Rule will necessitate redesigning of clinical protocols, patient flow, and the responsibilities and time management of staff across organizations and service sites, as well as determining how to document and monitor that new workflows are in compliance. Undergoing such organization-wide changes and re-trainings will require that, in the interim, services will be delayed or curtailed, leaving some patients to go without care.

47. In particular, we would also need to devote additional resources to observing

staff, as the Rule does not require an employee who refuses to provide certain services to notify a supervisor in advance, and we would be limited in our ability to ask employees. Unless we know what our employees are doing in the counseling or exam room, we will be unable to ensure the quality of our services. PHS already works with its network of sub-recipients to conduct compliance reviews using continuous quality monitoring and improvement practices as a core component of project management, to ensure the delivery of high quality family planning and related preventive health services. We also devote substantial time and energy to educating staff on the standards for non-judgmental, comprehensive reproductive health care, with the assumption that they will comply. Unless the Rule is blocked, PHS's Program Directors and other staff will need to spend even more time observing new hires and supervisors may need to do more frequent observations of employees and volunteers as they interact with clients in order to assure continued high quality of care. We would also need to review and revise our current grievance procedures for clients, and spend more time monitoring such grievances. However, it would be impossible to observe every client interaction, so there will be inevitable gaps in services for clients if staff can refuse care without notifying PHS.

48. I may also need outside legal counsel to determine how to provide services under some of the Rule's requirements that appear to conflict with mandates of other federal laws, as well as New York laws, that we are also obligated to follow. Under New York law, for instance, health professionals are prohibited from "abandoning or neglecting a patient or client under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care."[3] New York law also specifically mandates informed consent for

[3] 8 NYCRR § 29.2; *see also* N.Y. Educ. Law § 6530 (defining professional misconduct as the same).

patients.[4] Under our Title X grant, we must likewise provide non-directive options counseling and a broad range of contraceptives. I would need guidance to navigate complying with the Rule's proscriptions, while still meeting our legal and contractual obligations.

49. We will also be required to devote significant staff resources to a job that does not exist today: tracking and maintaining the data necessary to demonstrate that PHS and its sub-recipients are in compliance with the Rule.

The Rule's Impact on PHS's Ability to Compete for Title X Funds

50. PHS is not only concerned about losing Title X funding should it violate the Rule. Even if PHS complies, the Rule would allow other organizations to compete with PHS for Title X funds, even when those institutions refuse to provide non-directive options counseling to their patients—a fundamental requirement of Title X—because to reject them would be an adverse action, prohibited by the Rule. Through the Rule, HHS is significantly lowering the barrier for entry into the Title X program, and it is the patients who will suffer. If PHS loses Title X grant funding to other organizations that object to providing the full range of reproductive health care, counseling, and referrals required under Title X, then PHS will have to cut Title X programming and services, and our former patients will not be able to access the services they need.

51. PHS will also be forced to reconsider whether it will participate in the Title X program at all. While PHS has a longstanding history of successfully competing for Title X funds and administering the program, the Rule's new requirements would be costly and perhaps impossible to implement. It is deeply concerning that violating the Rule, which PHS is subject to in part because of its participation in the Title X program, could put in jeopardy all of PHS's federal funding, implicating all of our programming beyond the reproductive health areas. As a

[4] N.Y. Pub. Health L. § 2805-d.

result, PHS may not be able to participate in the Title X program if bound by the Rule.

52. The loss of federal HHS dollars would be devastating to PHS and to the tens of thousands of clients we serve, particularly those living deepest in poverty. Even if they are able to access other health care providers, there are few other options for reproductive health care so patients will have to wait longer for appointments, and not all providers prioritize continuity of care, cultural sensitivity, and patient dignity as we do. By contrast, we have provided health care in these communities for decades, and worked hard to build up trust among those who may otherwise be reluctant to seek care through a variety of strategies, including recruiting linguistically and culturally competent staff. In some cases, PHS has been serving clients for an entire generation. Additionally, low-income clients often have the least flexibility in their schedules due to their job schedules, lack of adequate childcare options, or other reasons. For these reasons, at PHS we offer a variety of options for clients, including visits to our health centers, home visits, and after hours care. But we could not do this if we lost our federal funding. If this happened, we would have to cut back on services and close our own health centers—not to mention the impact on our sub-recipients and the sites that they run. Cuts in services to patients will cause them irreparable harm, as well as degrading public health.

53. If PHS were no longer able to provide family planning services, it would have an immediate and irreparable impact on vulnerable communities in particular. For example, PHS and its sub-recipients all provide services designed for teens and young adults, and in 2017, adolescents 19 or younger comprised 16% of all PHS' Title X Family Planning Program clients. But if adolescents seeking respectful, confidential care feel stigmatized due to a denial of treatment, counseling, or a referral, they are unlikely to return for additional services, cutting off what is, in some cases, their only source of sexual health education and care. We also serve a

significant portion of undocumented immigrants, for whom we are often their only option to access health services. If we violate their trust by refusing services, then the consequences can be dire if they are unwilling to return to our health centers and cannot find assistance elsewhere. I note that this erosion of trust will exacerbate the widely reported decreased enrollment in Medicaid and use of health care (including family planning) and other services by eligible individuals due to fear of punishment arising from the publication of proposed changes to the public charge determination.

* * *

54. If the Rule is not blocked, PHS will immediately face a Hobson's choice: attempt to comply with the Rule (depriving untold numbers of our patients of the services to which they are legally and ethically entitled, damaging our longstanding reputation as health care providers, incurring tremendous compliance-related costs, and risking being found in violation of other state and federal laws governing patient care) *or* decline millions of dollars in federal funding (forcing the discontinuation of services and even closure of some health centers, and leaving the thousands of high-risk patients who depend on us with few, if any, options). Of course, even if we attempted to comply with the Rule, some of its requirements are so vague, that we could nevertheless be found out of compliance—and even if we are found out of compliance and attempt in good faith to come into compliance, the Rule still gives HHS the right to withhold any or all of our federal funds during that process.

55. For all these reasons, I ask the Court to prevent the serious harm the Rule would immediately inflict on both our patients and on PHS itself by stopping enforcement of the Rule.

I declare under penalty of perjury that the foregoing is true and correct. This declaration was executed on June 17, 2019, in New York, New York.

Lisa David

EXHIBIT F

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.; and PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, INC., Plaintiffs, v. ALEX M. AZAR II, in his official capacity as Secretary, United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROGER SEVERINO, in his official capacity as Director, Office for Civil Rights, United States Department of Health and Human Services; and OFFICE FOR CIVIL RIGHTS, United States Department of Health and Human Services, Defendants.	Civil Action No. 1:19-cv-5433 (rel. 1:19-cv-4676; 1:19-cv-5435)

DECLARATION OF STEPHEN TODD CHASEN

Stephen Todd Chasen, M.D., F.A.C.O.G., declares and states as follows:

1. I am board-certified in Obstetrics and Gynecology and Maternal Fetal Medicine, and I am licensed to practice in the state of New York. I am also a Fellow of the American Congress of Obstetricians and Gynecologists. I currently hold several professional positions: I am a Professor of Clinical Obstetrics and Gynecology at Weill Cornell Medical College, Cornell University, and I am an Attending Obstetrician and Gynecologist at New York Presbyterian Hospital. A more complete account of my professional qualifications and accomplishments is set forth on my Curriculum Vitae, attached hereto as Exhibit A.

2. I submit this declaration in support of Plaintiffs' Motion for a Preliminary Injunction, preventing the enforcement of a regulation promulgated by the U.S. Department of

Health and Human Services ("HHS") entitled "Protecting Statutory Conscience Rights in Health Care."

3. In my professional opinion, implementation of the Regulation could have devastating consequences for pregnant women who need emergency medical care because it appears to allow health care providers to refuse to provide medical care, even in emergencies.

Refusing to Provide Referrals or Information About Abortion is Unethical and Contrary to Informed Consent Principles

4. The American College of Obstetricians and Gynecologists ("ACOG") advises that upon a pregnancy diagnosis, a patient should be fully informed, in a balanced manner about all options, including carrying the pregnancy to term or having an abortion. American College of Obstetricians & Gynecologists ("ACOG"), *Guidelines for Women's Health Care: A Resource Manual* 719-20 (4th ed. 2014). Furthermore, the American Medical Association ("AMA") Code of Medical Ethics advises that withholding information without the patient's knowledge or consent is ethically unacceptable. American Medical Association ("AMA") Code of Medical Ethics § 2.1.3. The challenged rules would authorize health care providers to violate medical ethics and principles of informed consent by withholding information or referrals from a patient. Withholding information about or referral to an abortion provider in an emergency could be life-threatening.

5. ACOG also recognizes that health care providers may have religious or moral objections to providing certain health care, but those objections do not extend to providing information and referrals. ACOG, *The Limits of Conscientious Refusal in Reproductive Medicine*, No. 385 (Nov. 2007, reaffirmed 2016). Indeed, even when providers have an objection to the provision of a certain aspect of reproductive health care, "they must impart accurate and unbiased information so that patients can make informed decisions about their

health care." *Id*. at 5. Similarly, "[p]hysicians and other health care professionals have a duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that their patients requests." *Id*.

Medical Conditions That Require Emergency Abortions

6. While many women have relatively healthy and uncomplicated pregnancies, between 15 and 25% of pregnant women either spontaneously abort their pregnancies prior to 20 weeks gestation (this is sometimes called miscarriage), or develop serious medical complications that could pose a serious risk to the woman's life or health. Because of the frequency with which these situations arise, any health care provider who treats pregnant women will sometimes be faced with circumstances in which his or her patients seek prompt abortions to prevent harm to their health or life.

7. For some of these women, it would be medically inadvisable to postpone medical treatment to either end the pregnancy or to complete the abortion, if the abortion has begun spontaneously. Indeed, depending on the particular medical condition (some of which I discuss below), if there is any delay in ending a pregnancy because the hospital where she goes or is taken in an emergency refuses to provide this necessary care, the pregnant woman could suffer a variety of serious impairments, including: loss of future fertility, seizures, strokes, renal failure, and even death.

8. Even if the pregnant woman's condition does not seem like an absolute emergency when she first arrives at a hospital seeking care, delaying treatment may be dangerous, as some conditions can deteriorate quickly and dangerously: an infection that seems mild may quickly become severe; moderate hemorrhage may become uncontrollable without notice; an unruptured ectopic pregnancy can hemorrhage and/or rupture at any time, with very

serious, sometimes lethal, consequences. Because the course of a serious pregnancy complication cannot be predicted, if there is *any* meaningful risk to the woman's life from continuing the pregnancy, the standard of care requires that the woman not be turned away and that an abortion be performed or completed promptly.

9. In order to understand how dangerous the Regulation is for pregnant women in this country, I will describe some of the more common situations that can arise quickly (and often without notice) in pregnancy. In considering how the Regulation will affect emergency medical treatment of pregnant women, it is important to bear in mind that most women, especially low-income women, do not have the luxury of choosing what hospital to go to and will not know in advance if their hospital has a policy that prevents the medical treatment they may ultimately need, or whether hospital staff will refuse to provide the needed care. This is especially true for women in need of emergency care who typically arrive by ambulance or simply rush to the closest emergency room. Thus, women with symptoms of ectopic pregnancy or pregnancy loss may unexpectedly end up in the emergency room of a hospital without any way of knowing if they will be unable to obtain appropriate medical treatment to prevent serious health complications or even save their life.

Threatened, Inevitable, or Incomplete Abortion

10. Among the most common complications of pregnancy are "threatened abortion," "inevitable" abortion, and "incomplete" abortion. A patient experiencing these conditions typically presents with abdominal pain and vaginal bleeding. If she is bleeding, but the cervix is not dilated, the spontaneous abortion is "threatened," but not certain. If there is bleeding and cervical dilation, the spontaneous abortion is "inevitable." If there is bleeding, cervical dilation, and gestational tissue is in the vaginal canal or has passed from her body, the spontaneous

abortion has begun, but is incomplete. Even in the presence of heavy bleeding and cervical dilation ("inevitable" abortion), the embryo may have a visible heartbeat.

11. The indicated treatment for inevitable and incomplete abortion (with significant bleeding or pain), as well as threatened abortion with significant bleeding where the woman wants to terminate the pregnancy, is to induce or complete the abortion. Because an ultrasound performed when the woman presents with any one of these conditions often confirms the presence of cardiac activity, a health care provider who is opposed to abortion may refuse to complete an inevitable or incomplete abortion.

12. However, failure to induce or complete abortion promptly in a woman with inevitable or incomplete abortion and significant bleeding, pain or signs of infection places her at risk of worsening pain, hemorrhage and/or serious infection. While some women may not end up with serious complications if they are denied care, some inevitably will: severe hemorrhage can develop or infection can set in at any point. To prevent these life- and health-threatening occurrences, if the woman presents with serious bleeding, severe pain, or evidence of infection, it is advisable to evacuate the uterus without delay.

Preterm Rupture of the Membranes with Chorioamnionitis

13. Another risky situation that arises in pregnancy is called "preterm rupture of membranes," which describes the rupture -- prior to the 37th week of gestation -- of the membranes that surround a fetus and that contain amniotic fluid. Preterm rupture of membranes most often occurs spontaneously for reasons that are not well understood. It is an important cause of maternal morbidity and mortality and can lead to serious infection.

14. When a pregnant woman experiences a preterm rupture of membranes together with chorioamnionitis – an infection of the placental lining – it is typically necessary to terminate

her pregnancy. If the fetus has not yet reached the gestational age where it is viable, the accepted medical treatment is abortion.

15. Abortion is necessary because chorioamnionitis may cause severe infection of the reproductive tract and systemic sepsis – a serious infection that spreads throughout the body – if treatment is delayed. The infection can result in scarring of reproductive organs, sometimes necessitating their removal, and may be fatal if allowed to progress untreated.

16. For a physician to refuse to treat a patient with preterm rupture of membranes with chorioamnionitis would violate the standard of care. If the chorioamnionitis is severe, continued pregnancy is life-threatening. Even if the chorioamnionitis is relatively mild when the woman first presents, delaying treatment exposes her to a significantly increased risk of serious and even life-threatening infection that can develop rapidly and may not be brought under control with antibiotics. The presence of a fetal heartbeat does not change the risk of severe morbidity or death to the mother, and does not alter the obligation of a physician to promptly terminate the pregnancy to preserve maternal health.

Preeclampsia

17. Another condition that occurs in pregnancy is called "preeclampsia." It tends to occur toward the end of pregnancy, but can occur in the second trimester, prior to fetal viability, as well. Preeclampsia is a form of pregnancy-induced hypertension characterized by high blood pressure and proteinuria (excessive urinary protein). Patients with preeclampsia can also experience "eclampsia," characterized by grand mal seizures.

18. A patient with inadequately treated preeclampsia is at significant risk for cerebral hemorrhage (i.e. stroke), as well as liver dysfunction or failure, kidney failure, temporary or permanent visual disturbances or vision loss, coma, and death.

19. The only cure for severe preeclampsia is termination of the pregnancy. If severe preeclampsia occurs before the fetus has reached viability, the medically accepted treatment is abortion. To minimize the risk of significant physical injury or even death, it can be critical to stabilize the patient and then begin the abortion process without delay.

Placental Abruption

20. Some pregnant women develop a serious condition called placental abruption in which the placenta separates from the inner wall of the uterus, either partially or completely. Placental abruption can cause the woman to bleed heavily. If the fetus has not reached viability and the patient presents with severe hemorrhage, ending the pregnancy immediately is required to stop the bleeding.

Ectopic Pregnancy

21. A common complication of pregnancy is called "ectopic pregnancy." An ectopic pregnancy occurs whenever a fertilized egg – called a "blastocyst" at this stage – implants anywhere other than in the endometrial lining of the uterus. The vast majority of ectopic pregnancies involve a fertilized egg implanting in one of the fallopian tubes. In some cases, the pregnancy may develop significantly and cardiac activity may be present.

22. According to the Centers for Disease Control and Prevention, ectopic pregnancy accounts for approximately 2% of all reported pregnancies. Ruptured ectopic pregnancy is a significant cause of pregnancy-related mortality and morbidity, accounting for approximately 3.0% of all pregnancy-related deaths. It is the leading cause of obstetric hemorrhage-related mortality. The prevalence of ectopic pregnancy among women presenting to an emergency department with first-trimester vaginal bleeding, or abdominal pain, or both, has been reported to be as high as 18%. [ACOG Practice Bulletin #193. "Tubal Ectopic Pregnancy". The American

College of Obstetricians and Gynecologists: Washington DC, 2018.]

23. A fertilized egg that implants in one of the fallopian tubes may subsequently extrude into the peritoneal cavity. Such a "tubal abortion" typically occurs spontaneously and can result in hemorrhage.

24. A fertilized egg implanted in a fallopian tube may also cause the tube to rupture, resulting in hemorrhage.

25. In addition to life- or health-threatening hemorrhage, a ruptured tubal pregnancy can cause scarring of the tube, which can then result in either compromised fertility, infertility, and future ectopic pregnancy. An ectopic pregnancy can also attach to various organs, including the ovaries, the liver, and the intestines. These organs can be permanently compromised by the pregnancy.

26. An ectopic pregnancy generally requires either surgical or medical intervention. If no rupture has occurred, the ectopic pregnancy may often be terminated safely and effectively using the drug methotrexate. This drug causes the rapidly dividing cells comprising the pregnancy to die and to be either reabsorbed or expelled.

27. If surgery is necessary, such as in the case of a ruptured fallopian tube or impending rupture, it involves removing the pregnancy from the fallopian tube, and in some cases removal of a portion or all of the fallopian tube is required. Rarely, the ovary may be involved, and removal of the ovary may be necessary. In some circumstances, the implantation site may be such that removal of the entire uterus becomes necessary to protect the patient's life. Surgical intervention is less complicated and carries substantially less risk for the patient when performed before the ectopic pregnancy ruptures the fallopian tube or other organs.

28. Delaying treatment in cases of un-ruptured ectopic pregnancies exposes patients

to the risk of substantial physical harm and possibly of death. This is because at any moment, the patient may suddenly experience a rupture, requiring emergency surgery and resulting in permanent injury to one of more of her organs, or death from uncontrollable hemorrhage. Even if the woman does not die of hemorrhage, she may need blood transfusions, which carry their own risks.

29. To prevent the grave harms posed by an ectopic pregnancy, the standard of care for treating a suspected ectopic pregnancy does not permit delay in intervention. Indeed, any delay might well make the difference between a situation that may be treated with medication or relatively minor and uncomplicated surgery and an emergency procedure that carries greater risk of permanent injury or death.

Women Seeking Abortions Sometimes Need Emergency Care

30. Abortion is a very safe procedure. The overall abortion-related mortality rate in the United States is approximately 0.6 per 100,000 procedures (compared to a mortality rate for childbirth of approximately 8 per 100,000 women). Complications short of death are also very low. There are, however, occasions when women having abortions will need emergency care.

31. The most common serious complications occurring during surgical abortion procedures are uterine injury and/or hemorrhage. These conditions usually require immediate transfer from the health care facility where the abortion is being performed to a hospital. Delay in treatment once the woman arrives at the hospital could be catastrophic, leading to infertility or worse.

32. Often second-trimester surgical abortions are performed as a two-step, two-day procedure in which dilators are inserted into the woman's cervix on day one and the uterine evacuation is performed on day two. Patients return home between the two procedures. In a

very small percentage of cases, however, women go into labor at home as a result of the cervical dilators. These women often go to a hospital emergency room where they present in a similar condition to women who are in the midst of a miscarriage. If they are experiencing significant bleeding or have evidence of infection, they face all the same risks I describe above for women experiencing threatened, inevitable, or incomplete abortions, and require the same care.

33. Women having first-trimester medication abortions may also need hospital care. While this procedure is also extremely safe, a small percentage of patients undergoing medication abortion will experience significant blood loss. If these women call their health care provider, they may be told to go to the emergency room; other women will simply go to an emergency room on their own. Some medication abortion patients who are bleeding heavily do not require transfusions, but are best treated by completing the abortion surgically to stop the bleeding. Any delay in evacuating the uterus increases the risk that transfusion will become necessary.

34. Finally, some women who have already had a first- or second-trimester surgical abortion will develop serious complications a few days after the procedure is completed. The most common post-abortion serious complication is infection, the signs and symptoms of which usually arise within 48-96 hours post-abortion. In some cases, infection may be due to retained gestational tissue. If the woman first becomes aware of the symptoms (pain and fever) during normal business hours, and she lives near the health facility where the abortion was performed, she will often go there for treatment. However, if the symptoms develop over the weekend, or at night, or if the woman lives far from the abortion provider, she will generally go to the emergency room. Because untreated infection can result in chronic pelvic pain, infertility, or systemic sepsis and death, a high index of suspicion and expedient treatment are warranted.

35. Women in these circumstances may need immediate care, and this could include surgically evacuating any retained gestational tissue as well as administration of antibiotics. I am afraid that because the care they need could be seen as completing their abortions, or cooperating in the provision of abortion services, health care providers and hospital staff could refuse to provide or assist with that care, thereby threatening the lives and health of these women.

Conclusion

36. Based on ACOG's *The Limits of Conscientious Refusal in Reproductive Medicine*, No. 385 (Nov. 2007, reaffirmed 2016), "[a]ny conscientious refusal that conflicts with a patient's well-being should be accommodated only if the primary duty to the patient can be fulfilled." In an emergency, in which referral is not possible, "providers have an obligation to provide medically indicated and requested care regardless of the provider's personal moral objections."

37. If the Regulation is enforced, and if health care providers are permitted to refuse to provide necessary medical care to pregnant women even in an emergency, some women in this country will be subjected to sub-standard medical care, and will result in meaningfully increased maternal injury and mortality.

EXECUTED: June 13, 2019

I declare under penalty of perjury that the foregoing is true and correct.

Stephen Todd Chasen, M.D., F.A.C.O.G.