UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, et al., Plaintiffs, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	No. 1:19-cv-4676 (PAE) No. 1:19-cv-5433 (PAE) No. 1:19-cv-5435 (PAE)

NOTICE OF MOTION

PLEASE TAKE NOTICE that the undersigned, attorneys for Proposed Intervenors Dr. Regina Frost and the Christian Medical and Dental Associations ("CMDA") hereby move this Court for an order (1) granting Proposed Intervenors permission to submit the attached *amici curiae* brief and accompanying declarations in the above-captioned cases; (2) granting Proposed Intervenors permission to submit an over-length brief that complies with the briefing schedule that the Court established for the parties on June 7, 2019 (No. 19-cv-4676, ECF No. 27); (3) accepting for consideration the proposed over-length brief and declarations that have been filed electronically and duly served; (4) permitting counsel for Proposed Intervenors to present oral argument upon the Plaintiffs' motion for preliminary injunction; and (5) granting such other and further relief as this Court deems just and proper.

Dated: June 28, 2019

New York, New York

Respectfully submitted,

GIBSON, DUNN & CRUTCHER LLP

/s/ Allyson N. Ho

Daniel Blomberg (*pro hac vice forthcoming*)
Nicholas Reaves (*pro hac vice forthcoming*)
THE BECKET FUND FOR RELIGIOUS LIBERTY
1200 New Hampshire Ave. NW, Suite 700
Washington, D.C. 20036
Telephone: 202.955.0095
Facsimile: 202.955.0090

Allyson N. Ho (*pro hac vice*)
GIBSON, DUNN & CRUTCHER LLP
2100 McKinney Avenue, Suite 1100
Dallas, Texas 75201
Telephone: 214.698.3100
Facsimile: 214.571.2900

Robert E. Dunn (*pro hac vice forthcoming*)
GIBSON, DUNN & CRUTCHER LLP
1811 Page Mill Road
Palo Alto, California 94304
Telephone: 650.849.5300
Facsimile: 650.849.5333

Jason H. Hilborn (*pro hac vice forthcoming*)
GIBSON, DUNN & CRUTCHER LLP
1050 Connecticut Avenue, N.W.
Washington, DC 20036
Telephone: 202.955.8500
Facsimile: 202.467.0539

Attorneys for Amici (and Proposed Intervenors) DR. REGINA FROST AND CHRISTIAN MEDICAL AND DENTAL ASSOCIATIONS

Exhibit A

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, et al., Plaintiffs, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	:	No. 1:19-cv-4676 (PAE) No. 1:19-cv-5433 (PAE) No. 1:19-cv-5435 (PAE)

MEMORANDUM OF LAW OF *AMICI CURIAE* (AND PROPOSED INTERVENORS) DR. REGINA FROST AND CHRISTIAN MEDICAL AND DENTAL ASSOCIATIONS IN SUPPORT OF DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

GIBSON, DUNN & CRUTCHER LLP
2100 McKinney Avenue, Suite 1100
Dallas, Texas 75201
Telephone: 214.698.3100
Facsimile: 214.571.2900

THE BECKET FUND FOR RELIGIOUS LIBERTY
1200 New Hampshire Ave. NW, Suite 700
Washington, D.C. 20036
Telephone: 202.955.0095
Facsimile: 202.955.0090

Attorneys for Amici Curiae (and Proposed Intervenors) Dr. Regina Frost and Christian Medical and Dental Associations

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Regulations

Miscellaneous

I. PRELIMINARY STATEMENT AND INTEREST OF *AMICI CURIAE*[1]

From the Founding of our Nation, religious liberty and the right of conscience have enjoyed robust protections under the Constitution and federal law. Consistent with that tradition, Congress has enacted numerous conscience and anti-discrimination laws, particularly in the field of healthcare. These laws—including the Church, Coats-Snowe, and Weldon Amendments—require any State that takes federal funds to guard the conscience rights of healthcare professionals who refuse to perform or assist with procedures that violate their sincerely held religious beliefs.

Many of those protected individuals, including Dr. Regina Frost, are members of the Christian Medical & Dental Associations ("CMDA").[2] CMDA members have devoted themselves to providing compassionate care to all people, regardless of race, religion, sexual orientation, or gender. CMDA members seek to follow Jesus Christ's example by treating their patients with dignity and compassion. Many have spent their careers providing medical care to those most in need—including immigrants, children, the poor, and the uninsured—and many have used their skills overseas to care for victims of natural disasters, civil war, epidemics, and poverty.

CMDA members, including Dr. Frost, depend on federal conscience protections to ensure that they can practice their profession without violating their sincerely held religious beliefs. But a right unenforced is no right at all—and for too long States, local governments, and private employers have violated federal conscience statutes by pressuring healthcare professionals to act against their religious beliefs. As a result, thousands of doctors, nurses, and other professionals have suffered discrimination (and in some cases even termination) on account of their religious

---

[1] On June 26, 2019, the Court issued an order inviting Dr. Regina Frost and the Christian Medical and Dental Associations to file a brief as *amici curiae* pending resolution of their motion to intervene. ECF No. 73.

[2] A more fulsome description of CMDA and Dr. Frost, and their respective religious beliefs, are presented in their Memorandum Law in support of their Motion to Intervene. *See* ECF No. 65.

beliefs. Many of these individuals have been forced out of their practice areas, or have left the medical field altogether. Countless others have been deterred from entering the medical profession—or from entering certain specialties—by a fear of persecution. The failure to enforce federal conscience laws thus not only violates the conscience rights of healthcare professionals, but also negatively impacts patient care by driving away dedicated practitioners.

To ensure that religious healthcare professionals will no longer be unlawfully forced to choose between practicing their chosen profession and adhering to their religious beliefs, the Department of Health & Human Services ("HHS" or the "Department") promulgated the regulation at issue here: *Protecting Statutory Conscience Rights in Health Care; Delegations of Authority*, 84 Fed. Reg. 23,170 (May 21, 2019) ("Conscience Rule," or "Rule"). To effectuate the substantive requirements of the federal conscience provisions, the Rule requires employers to certify their compliance with federal law, and provides an enforcement mechanism to protect religious healthcare professionals from discrimination. The Department carefully considered comments from States and local governments (including Plaintiffs here) and adapted the Rule's provisions to provide employers with appropriate means of staffing their hospitals to provide patient care without interruption.

Despite having taken federal funds for decades subject to the conditions imposed by the federal conscience statutes, several States and local governments ("Plaintiffs") now claim that the Conscience Rule *implementing and enforcing* those statutes violates the Administrative Procedure Act, the Spending Clause, and the and the Separation of Powers. But Plaintiffs have no likelihood of success on the merits of those claims, which are essentially policy disagreements.

Nor do Plaintiffs come close to showing that the Conscience Rule will cause them irreparable harm. Plaintiffs speculate about future harms that may result if healthcare professionals

sandbag their employers by failing to disclose religious objections until the last moment, or discover heretofore unknown religious objections to transporting patients with ectopic pregnancies, or suddenly refuse to treat drug addicts in contravention of both the Hippocratic Oath and Christian doctrine. But Plaintiffs cannot satisfy the demanding standard for obtaining a preliminary injunction based on such speculation. More fundamentally, Plaintiffs' claims of irreparable harm are based on the erroneous assumption that medical professionals are currently violating their consciences, but will no longer do so once the Rule takes effect, forcing employers to double-staff or leave patients untreated. As the Department rightly concluded, that assumption is almost certainly false. The Conscience Rule likely *expands* access to healthcare by removing barriers to the practice of medicine, nursing, and other healthcare professions. And it unquestionably protects the fundamental right to conscience our country has recognized and zealously guarded for more than two hundred years.

For all these reasons, the Court should deny Plaintiffs' motion for preliminary injunction.

II. FACTUAL BACKGROUND

Since its founding in 1931, CMDA has educated and equipped its members—including Dr. Frost—to glorify God by serving with professional excellence as witnesses of Christ's love and compassion to all people. Declaration of Dr. David Stevens in Support of Opposition to Motion for Preliminary Injunction ("Stevens Decl.") ¶ 6. CMDA affirms that it is the duty of Christian healthcare professionals to treat *every* patient with compassion, "regardless of sexual orientation, gender identification, or family makeup." *Id.* ¶ 11. And this duty obtains even if doing so puts the professional's own safety at risk. *Id.* ¶¶ 11-12. In furtherance of this religious duty, CMDA doctors have served tens of thousands of patients in the midst of civil conflict in Somalia, genocide in Rwanda, and civil war in Sudan. *Id.* ¶¶ 4. CMDA holds, however, that performing certain

procedures—including abortion and euthanasia—is incompatible with the Christian faith. *Id.* ¶¶ 17-18. Some CMDA members have religious objections to other procedures, including sterilization, artificial contraception, and sex reassignment surgery. *Id.* ¶ 19; *see also* Declaration of Dr. Regina Frost in Support of Opposition to Motion for Preliminary Injunction ("Frost Decl.") ¶ 10. As CMDA recognizes, "[i]ssues of conscience arise when some aspect of medical care is in conflict with the personal beliefs and values of the patient or the healthcare professional." Stevens Decl. ¶ 9.

To protect CMDA members' ability to practice medicine in accord with their religious beliefs and medical judgment, CMDA has long advocated for legislative and regulatory action that would protect conscience rights. Stevens Decl. ¶ 9. Responding to concerns expressed by CMDA and others, Congress has repeatedly legislated conscience protections for healthcare providers. For example:

- **The Church Amendments** prohibit government entities that receive certain federal funds from discriminating against "those who hold religious beliefs or moral convictions regarding certain health care procedures," including abortion and sterilization. 84 Fed. Reg. at 23,171; *see* 42 U.S.C. § 300a-7(c)(1).

- **The Coats-Snowe Amendment** "applies nondiscrimination requirements to the Federal government, and to State and local governments receiving Federal financial assistance," and prohibits those government entities from "discriminat[ing] against any health care entity" that refuses to facilitate abortions or train its employees to perform abortions. 84 Fed. Reg. at 23, 171; *see* 42 U.S.C. §§ 238n(a), (c)(2).

- **The Weldon Amendment** strips federal funds from any federal agency, State, or local government that "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." 84 Fed. Reg. at 23,172; *see* Pub. L. No. 115-245 § 507(d)(1), 132 Stat. 2981, 3118 (2018).

- **The Patient Protection and Affordable Care Act ("ACA")** prohibits the federal government and any entity receiving federal funds under the ACA "from discriminating against an individual or institutional health care entity because of [its] objection to providing any health care items or service for the purpose of causing or assisting in causing death, such as by assisted suicide, euthanasia, or

> mercy killing." 84 Fed. Reg. at 23,172. The ACA also prohibits health plans offered through a healthcare exchange from "discriminat[ing] against any individual health care provider or health care facility because of the facility or provider's unwillingness to provide, pay for, provide coverage of, or refer for abortions." *Id.*; 42 U.S.C. §§ 18113, 18023(a)(1), (b)(1)(A), (b)(4).

Other appropriations bills and statutes similarly prohibit federally funded entities from violating the conscience rights of healthcare professionals who have religious objections to abortion, sterilization, or euthanasia. *Id.* at 23,172-74.

In 2008, recognizing the need to enforce the existing conscience rights of those in the healthcare field, HHS issued a regulation clarifying "the substantive requirements and applications of the Church, Coats-Snowe, and Weldon Amendments." 84 Fed. Reg. at 23,174; *see Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law*, 73 Fed. Reg. 78,072 (Dec. 19, 2008), *codified at* 45 C.F.R. § 88 (2008) (the "2008 Rule").

The 2008 Rule provided that those Amendments "and the implementing regulations '[we]re to be interpreted and implemented broadly to effectuate their protective purposes." 84 Fed. Reg. at 23,174 (quoting the 2008 Rule). It "required covered federally funded entities to provide written certification of compliance with the laws encompassed by the 2008 Rule." *Id.* And it "designated HHS [Office of Civil Rights] OCR to receive complaints based on the three specified Federal conscience and anti-discrimination laws, and directed OCR to coordinate handling those complaints with the Departmental components from which the covered entity receive[d] funding." *Id.* The certification requirement, in combination with the complaint mechanism, provided HHS with a means of ensuring compliance with federal conscience protections.

But in March 2009, just one month after the effective date of the 2008 Rule, HHS

unexpectedly proposed to rescind the rule. 74 Fed. Reg. 10,207 (Mar. 10, 2009). Over the objection of CMDA and thousands of medical personnel who submitted comments, HHS issued a new rule in 2011 that removed all of the substantive provisions of the 2008 Rule. *See Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws*, 76 Fed. Reg. 9,968 (Feb. 23, 2011), *codified at* 45 C.F.R. § 88.2 (2011) ("2011 Rule"). Although the 2011 Rule continued to designate OCR "to receive complaints based on the Federal health care provider conscience protection statutes," it eliminated the certification requirement, the primary enforcement mechanism put in place by the 2008 Rule. 84 Fed. Reg. at 23,174.

Shortly after the 2011 Rule was promulgated, numerous states and municipalities enacted laws infringing on the conscience rights protected by the Church, Coats-Snowe, and Weldon Amendments. *Id*. at 23,176-77. This, in turn, resulted in "an increase in lawsuits against State and local laws that plaintiffs allege[d] violate[d] conscience or unlawfully discriminate[d]." *Id.* at 23,176. Complaints filed with OCR alleging violations of federal law also significantly increased after the 2011 Rule, underscoring the need "for the Department to have the proper enforcement tools available to appropriately enforce all Federal conscience and anti-discrimination laws." *Id.* at 23,175.

To remedy the deficiencies in the 2011 Rule, HHS proposed a new rule "to enhance the awareness and enforcement of Federal health care conscience and associated anti-discrimination laws, to further conscience and religious freedom, and to protect the rights of individuals and entities to abstain from certain activities related to health care services without discrimination or retaliation." 83 Fed. Reg. 3,880, 3,881 (Jan. 26, 2018).

As HHS came to recognize, "adequate governmental enforcement mechanisms are critical" because federal conscience laws "do not contain, or imply, a private right of action to seek relief

from . . . violations by non-governmental covered entities." 84 Fed. Reg. at 23,178. Thus, for instance, a CMDA member's lawsuit for being denied a nursing position due to her objection to prescribing abortifacients failed because the court found that the Church Amendment did not provide a private right of action. *Hellwege v. Tampa Family Health Ctrs.*, 103 F. Supp. 3d 1303 (M.D. Fla. 2015); *see also Cenzon-DeCarlo v. Mount Sinai Hosp.*, 626 F.3d 695 (2d Cir. 2010) (Church Amendment did not provide a private right of action to a nurse alleging that private hospital forced her to assist in an abortion over her religious objections).

CMDA submitted comments in support of the revised rule, citing a 2009 survey of 2,865 members of faith-based medical associations conducted by the Christian Medical Association, which found that "39% [of respondents] reported having faced pressure or discrimination from administrators or faculty based on their moral, ethical, or religious beliefs." 84 Fed. Reg at 23,175. "Additionally, 32% of the survey respondents reported having been pressured to refer a patient for a procedure to which they had moral, ethical, or religious objections." *Id.* Without robust conscience protections, many of these healthcare providers may be forced out of their chosen profession. In fact, "91% of respondents reported that they 'would rather stop practicing medicine altogether than be forced to violate [their] conscience.'" *Id.*

CMDA's survey also indicated that conscience issues are affecting medical students' decisions about their medical careers—20% reported "that they would not pursue a career in obstetrics or gynecology because of perceived discrimination and coercion in that specialty against their beliefs." *Id.* at 23,175. CMDA's comment also cited a follow-up survey conducted in May 2011 of members of faith-based medical associations, which found that 82% of respondents thought "it was either 'very' or 'somewhat' likely that they personally would limit the scope of their practice of medicine if conscience rules were not in place." *Id.* at 23,181 n.48.

This evidence from CMDA helped "demonstrate" to HHS "that a lack of conscience protections diminishes the availability of qualified health care providers." *Id.* at 23,246. The Department expressed concerns that some "currently practicing health providers" who are leaving the profession "are motivated by coercion or discrimination based on providers' religious beliefs or moral convictions." *Id.* at 23,247. Consistent with this concern, CMDA member Dr. Frost is aware of several physicians who have been terminated or discriminated against because of their religious beliefs. Frost Decl. ¶ 13. And if she was confronted with similar pressure she would be forced to leave her practice. *Id.* ¶ 12-13.

To protect religious healthcare providers, the Department promulgated the Conscience Rule on May 21, 2019, recognizing that "[t]he freedoms of conscience and of religious exercise are foundational rights protected by the Constitution and numerous Federal statutes." 84 Fed. Reg. at 23,170. HHS "concluded[d] that there is a significant need to amend the 2011 Rule to ensure knowledge of, compliance with, and enforcement of Federal conscience and anti-discrimination laws." *Id.* The Conscience Rule makes clear that OCR "has a singular and critical responsibility to provide clear and appropriate interpretation of Federal conscience and anti-discrimination laws, to engage in outreach to protected parties and covered entities, to conduct compliance reviews, to investigate alleged violations, and to vigorously enforce those laws." *Id.* at 23,178.

The Conscience Rule's "substantive requirements" reflect existing federal statutes and regulations, often in "laws [that] have existed for decades." 84 Fed. Reg. at 23,222. The Conscience Rule accordingly reinstates the substantive provisions of the 2008 Final Rule and defines several key terms, including "assist in the performance," "health care entity," and "discrimination." *See* 24 C.F.R. § 88.2 (2019). The Conscience Rule also encourages recipients of federal funds to notify individuals and entities protected under federal conscience and anti-

discrimination laws—such as employees, job applicants, and students—of their conscience rights. *See id.* § 88.5.

Most importantly, the Rule requires these entities to certify to HHS their compliance with these laws, and provides OCR with tools for enforcing compliance. *See id.* §§ 88.4, 88.6, & 88.7. The Rule explains that "[i]mplementation of the requirements set forth in this final rule will be conducted in the same way that OCR implements other civil rights requirements (such as the prohibition of discrimination on the basis of race, color, or national origin)," and that "[e]nforcement will be based on complaints, referrals, and other information OCR may receive about potential violations[.]" 84 Fed. Reg. at 23,179-80.

If OCR concludes an entity is non-compliant, it will, in consultation and coordination with HHS's funding components, "assist covered entities with corrective action or compliance, or require violators to come into compliance." *Id.* at 23,180. If corrective action is not satisfactory or compliance is not achieved, OCR "may consider all legal options available to the Department, to overcome the effects of such discrimination or violations," including "termination of relevant funding, either in whole or in part, funding claw backs to the extent permitted by law, voluntary resolution agreements, referral to the Department of Justice (in consultation and coordination with the Department's Office of the General Counsel), or other measures." *Id.*

In promulgating the Conscience Rule, the Department considered many of the concerns raised by Plaintiffs here about the Rule's potential costs and impacts on patient care. The Conscience Rule thoughtfully responds to these concerns, and describes the modifications the Department made to the proposed rule to accommodate them. *See id.* at 23,180-23,226.

For example, the Department considered concerns that the Rule would decrease access to health care for certain patient groups and in certain parts of the country, such as rural areas. 84

Fed. Reg. at 23,253-54. The Department explained that "studies have specifically found that there is insufficient evidence to conclude that conscience protections have negative effects on access to care." *Id.* at 23180. The Department also looked to "academic literature on the benefits of conscience protections in health care," which "supports the proposition that prohibiting the exercise of conscience rights in medicine *decreases* the quality of care that patients receive." *Id.* at 23,246 (emphasis added).

Although the Department received numerous comments expressing concern that the Conscience Rule would result in a decrease in care, these comments failed to provide reliable data. 84 Fed. Reg. at 23,247. The Department thus looked to the tens of thousands of comments it received in 2009 asserting that doctors and future doctors with religious objections would leave or not enter the profession if the Department failed to act to protect conscience rights. *Id.* at 23,175-76. The Department concluded that the Conscience Rule would actually "remove barriers to entry into the health care professions," and thus found it "reasonable to assume that the rule may … *increase,* not decrease, access to care." *Id.* at 23,180 (emphasis added); *see also id.* at 23,210 (concluding that "conscience protection ensures diversity in the health care industry and maximizes the number of health care professionals in the United States, which helps *all* patients").

The Department also recognized that conscience protections provide little benefit if they are not enforced. 84 Fed. Reg. at 23,253. Rigorous enforcement of "Federal conscience and anti-discrimination laws" is necessary to "prevent health care providers from being unlawfully driven out of business." *Id.* Without the Conscience Rule, the Department explained, "[i]nstead of a decrease in access to a particular *procedure* from a particular doctor or provider, the residents of a rural area would face the potential of receiving no health care *at all* from that doctor or provider because such providers may leave the practice if unable to practice medicine according to their

religious beliefs or moral convictions." *Id.* at 23,254 (emphases added).

Many of the same commenters who argued that the Rule would limit access to health care also argued that rule was unnecessary because existing policies adequately protected conscience rights. 84 Fed. Reg. at 23,180. As the Department recognized, those arguments are contradictory: "If the Department's new rule would decrease access to care because of an increase in providers' exercise of conscientious objections, it would seem that the statutory protections that existed before the regulation did not result in providers fully exercising their consciences as protected by law." *Id.*

The Department also considered and addressed comments arguing that employers should be allowed to ask employees (and prospective employees) about their religious beliefs both before and after they are hired. The Department reasoned that "it is not an acceptable practice under Federal conscience and antidiscrimination 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. Still, to accommodate these concerns, the Department modified the Rule so that "employers may require a protected employee to inform them of objections . . . to the extent there is a reasonable likelihood that [they] may be asked in good faith to" engage in the objected-to conduct. *Id.*

The Department also added a provision clarifying that "[a]n employer may similarly require an employee to notify them in a timely manner of an actual conscientious objection that the employee has to a specific act, in the day-to-day course of work, that the employee would otherwise be expected to perform." 84 Fed. Reg. at 23,201. The Department believed that these additions "str[uck] the right balance," furthering the interests of employers, patients, and healthcare professionals. *Id.* at 23,192.

Finally, some commenters expressed uncertainty about whether the Rule would allow them to offer accommodations to religious objectors. To provide clarity, the Department modified the definition of "discrimination" "to make clear that employers can use, and are encouraged to pursue, accommodation procedures with protected employees." 84 Fed. Reg. at 23,201. The Department added that it "will take into account an entity's adoption and implementation of policies to accommodate objecting persons in making determinations of discrimination." *Id.* at 23,191.

Notwithstanding the Department's efforts to satisfy the concerns raised during the notice-and-comment process, Plaintiffs—a collection of States and municipalities—have sued to invalidate the Rule and seek a preliminary injunction.[3]

III. ARGUMENT

A preliminary injunction "is an extraordinary and drastic remedy," *Moore v. Consol. Edison Co. of New York*, 409 F.3d 506, 510 (2d Cir. 2005), and requires "a clear showing that the plaintiff is entitled" to it. *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 22 (2008). The Court should deny Plaintiffs' request for this extraordinary relief because they have failed to "establish that [they are] likely to succeed on the merits, that [they are] likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in [their] favor, [or] that an injunction is in the public interest." *Id.* at 20.

A. Plaintiffs Will Not Suffer Irreparable Harm When The Final Rule Goes Into Effect.

Preliminary relief cannot be awarded if it is "based only on a *possibility* of irreparable harm." *Winter*, 555 U.S. at 22 (emphasis added). The alleged injury must be "neither remote nor

[3] This brief responds primarily to the arguments raised by the Plaintiffs in No. 1:19-cv-04676-PAE, the case in which Dr. Frost and CMDA have sought to intervene. Unless otherwise specified, "Plaintiffs" refers to these Plaintiffs, and "Mot." refers to their motion for a preliminary injunction.

speculative, but actual and imminent." *Faiveley Transp. Malmo AB v. Wabtec Corp.*, 559 F.3d 110, 118 (2d Cir. 2009); *see also Moore*, 409 F.3d at 511 (affirming denial of preliminary injunction because alleged harm was "too speculative"). But remote, speculative predictions are the best Plaintiffs can offer.

To hear Plaintiffs tell it, the Conscience Rule thrusts them upon the "horns of [a] dilemma"—either incur massive compliance costs while "threatening patient health," or disregard the Rule and risk the loss of "billions of dollars in health care funds." Mot. 10-11.[4] But Plaintiffs have failed to demonstrate any "actual or imminent" threat to patient health—because there is none—and alleged "[i]njury resulting from attempted compliance with government regulation ordinarily is not irreparable harm," *Freedom Holdings, Inc. v. Spitzer*, 408 F.3d 112, 115 (2d Cir. 2005), especially when the regulation merely enforces longstanding federal statutes that Plaintiffs should have been complying with for decades.

Further, Plaintiffs attempt to manufacture irreparable harm by inventing religious beliefs that no one has ever asserted, to create conundrums that have never existed, to eventually arrive at speculative injury that *might* occur. Along the way, they disparage sincere religious believers by conflating genuine religious objections with ugly personal bias. That is not the stuff of irreparable harm.

[4] Plaintiffs cite a "line of decisions" applying the principle that when a deprivation of First Amendment rights is involved, the plaintiff need not show further injury to obtain a preliminary injunction. Mot. 11 n.9. But Plaintiffs—governmental entities—have not alleged any cognizable constitutional injury. Regardless, even for an alleged violation of sacrosanct First Amendment rights—the loss of which "for even minimal periods of time, unquestionably constitutes irreparable injury," *Elrod v. Burns*, 427 U.S. 347, 373 (1976)—irreparable injury "must still be shown" "rather than simply presumed." *Bronx Household of Faith v. Bd. of Educ. of City of New York*, 331 F.3d 342, 349 (2d Cir. 2003).

1. Plaintiffs have failed to provide anything but speculation that patient care will be adversely affected by the Conscience Rule.

Plaintiffs assert that the Conscience Rule would hinder "their ability to deliver effective patient care," because it allegedly "expands who can object and what they can object to." Mot. 15, 17. But their claims of injury are impermissibly speculative.

a. Plaintiffs badly misunderstand both the Rule and the role religion plays in the lives of healthcare professionals.

Plaintiffs speculate that "drivers, pilots, and EMTs—whose job "is to keep a patient alive en route to a hospital"—may refuse to transport sick or injured patients because of an unspecified religious objection. Not surprisingly, Plaintiffs do not point to a single instance in which an EMT helicopter pilot or ambulance driver has *ever* refused to transport a patient because of a religious objection to a specific medical procedure. Nor have they shown that any claimant has ever sought such an accommodation under any of the federal statutes that have protected conscience rights for decades. Nor do they bother to explain why an EMT's unavailability due to a known religious objection would somehow be more logistically problematic than their unavailability due to a known injury or illness. *Fraternal Order of Police Newark Lodge No. 12 v. City of Newark*, 170 F.3d 359, 366 (3d Cir. 1999) (finding that police station's employment policy cannot make a "value judgment in favor of secular motivations, but not religious motivations").

Plaintiffs also vaguely assert that the Conscience Rule will irreparably harm "states with large rural areas"—such as Hawaii—because of the supposed "risk that an employee may object to providing care without notice." Mot. 20. But again, Plaintiffs have not identified any real-world examples (presumably because they cannot).

Plaintiffs further speculate that the Conscience Rule may interfere with family members' ability to "remov[e] life-sustaining treatment . . . like extubating a terminally-ill patient," because a physician or nurse may object at the last minute to removing the respirator. Mot. 21. Plaintiffs

contend this will require them to incur the expense of "double-staffing" their hospitals to ensure that someone is available to "remov[e] life support." *Id*. But these decisions are typically made in consultation with an attending physician (not in an emergency setting), and Plaintiffs offer no evidence that religious healthcare professionals conceal their religious objections until the last minute.[5] That is certainly not Dr. Frost's practice. Frost Decl. ¶ 12. If anything, the Conscience Rule removes the pressure that religious objectors might feel to hide their beliefs, thus making accommodation practicable.

Plaintiffs have also submitted a raft of declarations with even more speculation about how the Rule might harm patients. This parade of horribles includes assertions that:

- "[U]nder the Final Rule, an employee could refuse to … provide janitorial services to an LGBTQIA+ person." Ex. 44 ¶ 12.
- "[A] health care professional could refuse to test or treat based on a personal bias and judgment call against a pregnant mother." Ex. 48 ¶ 38.
- "If a doctor objects to performing emergency surgery on a woman bleeding out after an abortion, sterilization, or some other procedure or post-partum event, it is unclear whether the Final Rule permits … any review of the doctor's decision[]." Ex. 48 ¶ 71.
- "One also can reasonably anticipate moral objections to providing health care services to women suffering from addictions to drugs or alcohol or who have been charged with a crime." Ex. 39 ¶ 19.
- "[U]nder the Final Rule, any employee may object … to providing any of the innumerable mental health services … to the persons with mental health disorders." Ex. 44 ¶ 12.
- "The Rule could also allow providers to deny services to entire Michigan populations, such as minors, unmarried clients, clients living with HIV/AIDs, and LGBTQ people." Ex. 10 ¶ 7.

[5] Even if a physician were to object at the last minute to extubating a terminal patient, it is difficult to see how Plaintiffs are irreparably harmed if the objection results in "extending the life of a patient," Mot. 21. Setting aside the questionable morality of Plaintiffs' argument, hospital procedures are often delayed for any number of anodyne reasons—physicians get stuck in traffic, are busy treating other emergent patients, or have emergencies of their own. The speculative delay Plaintiffs contemplate does not rise to the level of irreparable harm.

- The "Rule would allow medical personnel to discriminate at will and refuse service once they find out that a person may be … part of a particular protected class." Ex. 31 ¶ 24.

- The Rule would exacerbate "[p]ediatricians refusing to treat the children of same-gender couples"; "[e]mergency [d]epartment/[e]mergency [m]edical [s]ervices workers refusing to transport or provide emergency care to minority patients"; and "[m]edical professionals denying care to individuals who have had abortions at any point for any reason." Ex. 28 ¶ 32.

Plaintiffs have not even attempted to explain which provisions of the Conscience Rule would protect a healthcare professional who declines to clean an LGBTQIA+ person's sheets, refuses psychiatric help to a bipolar patient, or withholds healthcare from a drug-addicted woman. That is because Rule does *not* protect such invidious discrimination. It protects healthcare professionals who have religious objections to particular *procedures*—most importantly, abortion and euthanasia—not to particular *patients*. Plaintiffs are falsely equating rights of conscience, which the Rule protects, with "personal bias," which it does not.

Plaintiffs' unspoken (and unsupported) assumptions that religious healthcare professionals will respond to the rule by discriminating against "minors," "unmarried persons," those with HIV, those suffering from addiction, or patients of a different race badly misunderstand the role that religious belief plays in the lives of thousands of Christian healthcare professionals—many of whom are CMDA members—committed to fulfilling Christ's command to "love your neighbor as yourself." *Matthew* 22:39 (English Standard Version); *see* Stevens Decl. ¶ 6; Frost Decl. ¶ 8-9. The Oath that CMDA encourages its members to take affirms that physicians must "love those who come to [them] for healing and comfort" and to "car[e] for the lonely, the poor, the suffering, and the dying." Stevens Decl. ¶ 6.[6]

[6] For example, CMDA's official policy on AIDS states: "We extend compassion to all who have acquired this disease by whatever means. We urge the provision of medical care for them

Most important, because they are "guided by Christ, who assisted all who sought his help regardless of sexual or social status," Christian healthcare professionals "care for all patients in need, regardless of sexual orientation, gender identification, or family makeup, with sensitivity and compassion." *Id.* ¶ 11. As the Department recognized, they are "motivated by their beliefs to serve [underserved or underprivileged] communities." 84. Fed. Reg. at 23,248. Christian doctors and nurses serve across the country in clinics that focus on the "neediest members of society, including the uninsured, immigrants, and children." Stevens Decl. ¶ 14. They travel to remote areas throughout the world to serve patients in need, often risking their personal health and safety to do so. *Id.* ¶ 4. Sometimes this service takes them directly into the center of public health emergencies—like HIV and Ebola crises—as well as civil war or other armed conflict. *Id.* In short, Plaintiffs' suggestion that religious healthcare professionals may invoke the Conscience Rule to recklessly endanger or abandon their patients has no basis in reality, no evidentiary support, and does not come close to establishing irreparable harm. Such irrational speculation against religious beliefs itself borders on bigotry.

b. The Rule's definitions do not irreparably harm Plaintiffs

Plaintiffs point to three definitions in the Conscience Rule that, they allege, will "dramatically expand" conscience protections and "require[e] extreme departures from existing practice": "discrimination," "health care entity," and "assist in the performance." Mot. 16. Plaintiffs assert that these new definitions will cause significant understaffing at times of need or require institutions to expend more money on staffing. But this argument assumes that medical professionals protected by the Conscience Rule would, absent the Rule, subvert their consciences and perform

---

to the same degree that patients with other life-threatening diseases receive it. Christian physicians and dentists, following the example of Christ, should care for HIV-infected persons even at the risk of their own lives. We encourage all healthcare workers to do the same." Stevens Decl. ¶ 12.

abortions or other procedures that violate their religious beliefs. *See* 84 Fed. Reg. at 23,252 ("Commenters … assume all providers with conscientious objections that are not being honored are providing those services anyway."). That may be true in some cases, but it is more likely, as the Department concluded, that religious healthcare professionals confronted with increasing attacks on their conscience rights will leave the profession or their specific practice area. *Id.* At minimum, this ambiguity precludes Plaintiffs from establishing irreparable harm. *See Simmons v. Blodgett*, 110 F.3d 39, 42 (9th Cir. 1997), *as amended* (Apr. 18, 1997) ("when the scales are evenly balanced and the relevant evidence leaves a trier of fact in 'equipoise,' the party with the burden of proof loses.").

The Department received "*[t]ens of thousands* of comments" from healthcare professionals stating that without increased enforcement of federal conscience laws, "individuals with conscientious objections simply would not enter the health care field, or would leave the profession, and hospitals *would shut down*." 84. Fed. Reg. at 23,175-76 (emphases added). For example, the 2,500 members of the American Association of Pro-Life Obstetricians and Gynecologists "overwhelmingly would leave the medical profession—or relocate to a more conscience-friendly jurisdiction" if asked to violate their consciences. *Id.* at 23,247. As Dr. Frost has stated, if she were "ever directed . . . to perform a procedure to which [she] ha[d] a religious objection, [she] would be compelled to resign or to leave the practice of medicine." Frost Decl. ¶ 12.

If anything, Plaintiffs likely face *greater* staffing concerns in a world *without* the Conscience Rule. And even if the Court were to accept Plaintiffs' counterfactual assumption that religious healthcare professionals who had previously subverted their religious beliefs will suddenly begin to object, Plaintiffs assert only that "it is unclear" whether they "can feasibly manage"

the budgetary burdens of adding staff. Mot. 18. Vague concerns about theoretical compliance costs that *may* prove infeasible do not establish "actual" or "imminent" harm.[7]

In all events, Plaintiffs fail to offer anything but speculation that these three definitions will harm patients. Plaintiffs focus on paragraphs (4), (5), and (6) of the definition of "discriminate," Mot. 16-17, but those paragraphs were added in response to "comments expressing concern that the proposed definition . . . would prohibit employers from accommodating religious objections by placing the conscientious objector in a different position, potentially requiring the double-staffing of certain positions. 84 Fed. Reg. at 23,191. For example, paragraph (4) "recognizes that staffing arrangements can be acceptable accommodations in certain circumstances." *Id.* And the Department "add[ed] new paragraphs (5) and (6) to clarify that, within limits, employers may require a protected employee to inform them of objections to referring for, participating, or assisting in the performance of specific procedures, programs, research, counseling, or treatments to the extent there is a reasonable likelihood that the protected entity or individual may be asked in good faith to refer for, participate in, or assist in the performance of such conduct." *Id.*; *see also id.* at 23,263 (allowing employers to ask employees about any objected-to procedures once per year, and additional times as the issue arises so long as the employer has a "persuasive justification").

The Department added language to the definition of "discriminate" to prevent hospitals (and patients) from being injured by physicians who fail to disclose their religious beliefs until the moment they are asked to perform procedures to which they object. Plaintiffs fail to explain why

[7] Plaintiffs claim to have policies in place that already allow employees to object in advance to certain procedures, and provide staffing to accommodate religious objections. Mot. 15-16. Under the Conscience Rule, Plaintiffs can ask their employees about any objected-to procedures once a year. 84 Fed. Reg. at 23,263. Plaintiffs do not explain why their current procedures to coordinate staffing will be ineffective under the Conscience Rule. Nor do they explain why the new policies they will supposedly be required to implement under the Conscience Rule are immeasurably more burdensome than their existing policies.

they cannot staff their institutions appropriately in light of this carve-out. Nor have they provided evidence that OCR is likely to discipline them for providing inadequate accommodations. The Rule clarifies that "OCR will take into account the degree to which an entity had implemented policies to provide effective accommodations . . . and whether or not the entity took any adverse action against a protected entity." 84 Fed. Reg. at 23,263.

Plaintiffs also assert that the definition of "assist in the performance," in combination with the definition of "health care entity," will increase "the universe of Plaintiffs' employees who may object, and the services those employees may object to providing." Mot. 17. But Plaintiffs' speculation that the Rule "*appears* to include" "desk receptionists" and insurance "clerks," Mot. 17 (emphasis added), is not irreparable harm. Even if the Rule does apply to these non-medical personnel—which is dubious—Plaintiffs do not even hint at the types of objections they might raise in the course of their daily tasks, or how those hypothetical objections would harm Plaintiffs.

c. Plaintiffs create fictional religious objections to manufacture injury.

Plaintiffs assert that a patient coming to the emergency room with an ectopic pregnancy might be left untreated. Mot. 18. But their source for this assertion—a New York physician—admits that "the prevailing medical understanding is that medical treatment to address an ectopic pregnancy does not constitute an 'abortion.'" Ex. 29 ¶ 10. He then asserts, without reference to any source, that "some individuals . . . believe such treatment amount to the termination of a pregnancy." *Id.* But that is not the prevailing understanding among Christian doctors, including CMDA's members. Frost Decl. ¶ 14-15; Stevens Decl. ¶ 20. Catholic ethicists have also identified "morally licit" methods of removing ectopic pregnancies. The National Catholic Bioethics Center,

Catholic Health Care Ethics, A Manual for Practitioners 123 (Furton et al., eds., 2d ed. 2009).[8] Plaintiffs cannot establish irreparable harm based on a single physician's speculation about what "some" people believe.

Plaintiffs similarly assert that "some consider" treatment for a miscarriage to be "abortion," but their source for this statement was merely listing the staff typically involved in treating a miscarriage. Ex. 5 ¶¶ 26-29. Neither Dr. Frost, a Christian OBGYN, nor CMDA has ever taken the position that treating a miscarriage is morally wrong. Stevens Decl. ¶ 21; Frost Decl. ¶ 16. Nor do Plaintiffs identify a single faith tradition that teaches that providing care for a woman going through a miscarriage is religiously objectionable. Thus, Plaintiffs have again failed to show that *patients* will be actually or imminently harmed by the Conscience Rule, because they have failed to provide evidence that any actual healthcare providers have the religious beliefs that may cause the problems they suggest.

2. Plaintiffs have failed to show that compliance with the Rule will cause them irreparable harm.

Plaintiffs complain that they will be required to expend time and resources, and "change a wide range of policies and practices," to comply with the Conscience Rule. Mot. 11, 22-23. But, again, "injury resulting from attempted compliance with government regulation ordinarily is not irreparable harm." *Freedom Holdings*, 408 F.3d at 115 (quoting *Am. Hosp. Ass'n v. Harris*, 625 F.2d 1328, 1331 (7th Cir. 1980)).

[8] The Pontifical Council established to clarify the Catholic Church's beliefs regarding health care explains that "interventions aimed exclusively at preserving the life and health of the woman" which incidentally "result in [an] embryo's demise" can be permissible because "[t]he woman may face a serious risk to her life or suffer consequences for her future fertility, while the embryo as a rule cannot survive." Pontifical Council for Pastoral Assistance to Health Care Workers, *New Charter for Health Care Workers* ¶ 57 (2016), *available at* https://www.ncbcenter.org/resources/church-documents-bioethics/new-charter-health-care-workers/.

In *American Hospital*, the court held that the plaintiffs failed to establish irreparable harm, even though, as here, they alleged that the "new regulations may force . . . hospitals to rearrange . . . medical staffs and organizational policies," and that the "administrative costs of compliance with the regulations will be high." 625 F.2d at 1331. Denying the plaintiff's request for a preliminary injunction, the court observed that "many of the complained of costs should already have been incurred prior to the hearing on the preliminary injunction." *Id.* That is especially true here, where the substantive provisions merely echo longstanding statutory requirements that Plaintiffs have been required to follow for decades as a condition of receiving federal funds.

B. A Preliminary Injunction Is Not In The Public Interest.

Courts "balance the competing claims of injury and must consider the effect on each party of the granting or withholding of the requested relief." *Winter*, 555 U.S. at 24 (internal quotation marks and citation omitted). They must also determine "the public consequences of employing the extraordinary remedy of injunction." *Id*. Here, Plaintiffs have failed to show that the public interest supports an injunction because, in addition to overstating their alleged harms, they ignore the harm an injunction would cause to the *beneficiaries* of the Rule, including Dr. Frost and the nearly 20,000 other members of CMDA. *See Action for Bos. Cmty. Dev., Inc. v. Shalala*, 983 F. Supp. 222, 244 (D. Mass. 1997), *aff'd*, 136 F.3d 29 (1st Cir. 1998) (balance of equities and public interest weigh against enjoining government program where injunction would harm program's "intended beneficiaries").

The vast majority of CMDA's members, including Dr. Frost, object on religious grounds to performing, assisting, or facilitating certain procedures, such as abortion and euthanasia. As CMDA explained during the rulemaking, many of its members have suffered adverse employment consequences for refusing to participate in these procedures. *See* 84 Fed. Reg. at 23,175. Without

conscience protections, many CMDA members may be compelled to leave the practice of medicine altogether. *Id.*; *see also id.* at 23,181 n.48 ("82% of medical professionals said it was either 'very' or 'somewhat' likely that they personally would limit the scope of their practice of medicine if conscience rules were not in place."). The Department identified numerous complaints alleging that religious healthcare professionals were targeted for their beliefs or disciplined for refusing to perform or assist in the performance of procedures that violate their consciences. 84 Fed. Reg. at 23,176-79.[9] For example, twelve nurses in New Jersey sued a public hospital over a policy allegedly requiring them to assist in abortions. Compl., *Danquah v. University of Medicine and Dentistry of New Jersey*, No. 2:11-cv-6377 (D.N.J. Oct. 31, 2011). The Department also recognized that certain advocacy organizations, taking advantage of the lack of robust conscience protections, had sued *to compel* religious healthcare professionals to perform abortions and sterilizations. 84 Fed. Reg. at 23,178.[10]

The Department issued the Conscience Rule to prevent these types of violations from continuing and to protect the religious liberty of healthcare professionals. *See* 84 Fed. Reg. at 23,170 & 23,175. "Protecting religious liberty and conscience is obviously in the public interest." *California v. Azar,* 911 F.3d 558, 582 (9th Cir. 2018), *cert. denied sub nom. The Little Sisters of the*

[9] *See, e.g.*, *Roman Catholic Diocese of Albany v. Vullo*, No. 02070-16 (N.Y. Albany County S. Ct. May 4, 2016); *Means v. U.S. Conf. of Catholic Bishops*, 2015 WL 3970046 (W.D. Mich. June 30, 2015); *ACLU v. Trinity Health Corp.*, 178 F. Supp. 3d 614 (E.D. Mich. 2016); *Minton v. Dignity Health*, No. 17-558259 (Cal. Super. Ct. Apr. 19, 2017); *Chamorro v. Dignity Health*, No. 15-549626 (Cal. Super. Ct. Dec. 28, 2015); *Mendoza v. Martell*, No. 2016–6–160 (Ill. 17th Jud. Cir. June 8, 2016); *Cenzon-DeCarlo*, 626 F.3d at 696; *Hellwege*, 103 F. Supp. 3d at 1306; *see also* 84 Fed. Reg. at 23,176.

[10] *See Means,* 2015 WL 3970046 (abortion); *Trinity Health Corp.,* 178 F. Supp. 3d 614 (abortion); *Minton,* No. 17–558259 (Cal. Super. Ct. Apr. 19, 2017) (hysterectomy); *Chamorro,* No. 15–549626 (Cal. Super. Ct. Dec. 28, 2015) (tubal ligation); *Coffey v. Pub. Hosp. Dist. No. 1,* 20–15–2–00217–4 (Wash. Super. Ct. May 7, 2015).

Poor Jeanne Jugan Residence v. California, No. 18-1192, 2019 WL 1207008 (U.S. June 17, 2019); *Hobby Lobby Stores, Inc. v. Sebelius*, 723 F.3d 1114, 1147 (10th Cir. 2013) (en banc) (upholding religious liberty rights "is always in the public interest"). The Department concluded that "a lack of conscience protections diminishes the availability of qualified health care providers," and that the Final Rule would "remove barriers to entry of certain health professionals" and "delay the exit of certain health professionals from the field, by reducing discrimination or coercion." 84 Fed. Reg. at 23,246. As the Department recognized, the Rule "will promote protection of religious beliefs and moral convictions, which is a societal good based on fundamental rights." *Id.*; *see also id.* at 23,246-55 (explaining in detail the Rule's expected benefits).

The Conscience Rule ensures that healthcare providers are not put to the painful choice of either suffering discrimination (and possibly termination) for following their convictions, or participating in procedures that violate their sincerely held religious beliefs. Because enjoining the Rule would significantly injure the "fundamentally important" conscience rights of religious healthcare professionals, *Azar,* 911 F.3d at 582, an injunction is not in the public interest.

Plaintiffs do not even *mention* the harms an injunction would inflict on the beneficiaries of the Rule. Instead, they assert only that the "Department will suffer no harm" because "the relevant federal statutes will continue to apply." Mot. 24.[11] But the Department promulgated the Rule to "ensure" that these statutes, which states and municipalities have been violating, are "appropriately enforce[d]." 84 Fed. Reg. at 23,175. "There is inherent harm to an agency in preventing it from enforcing regulations that Congress found it in the public interest to direct an agency to develop

[11] Given that the Rule merely enforces these federal statutes, Plaintiffs' concession that the statutes themselves impose no harm defeats any claim of irreparable injury. The Department's promise to delay enforcement of the Rule until November 22, 2019, further undermines any suggestion that the Rule threatens irreparable harm.

and enforce." *Nat'l Propane Gas Ass'n v. U.S. Dep't of Homeland Sec.*, 534 F. Supp. 2d 16, 20 (D.D.C. 2008). And regardless whether *the Department* is harmed, the public interest weighs heavily against an injunction because the Conscience Rule is necessary to protect CMDA members and other religious healthcare professionals from being pressured to violate their consciences or facing discrimination (and even termination) on account of their religious beliefs.

C. Plaintiffs Are Unlikely To Succeed On The Merits.

Because Plaintiffs cannot establish irreparable harm or that a preliminary injunction is in the public interest, the Court need not reach the merits at this early stage of the case. If it does, it should deny Plaintiffs' requested relief for the additional reason that the Conscience Rule does not violate the Administrative Procedure Act ("APA"), any other federal statute, or the Constitution.

1. The Conscience Rule does not exceed statutory authorization.

The APA provides that when agency action is "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right," it is unlawful and must be set aside. 5 U.S.C. § 706(2)(C). Plaintiffs contend that the Conscience Rule violates this provision because it stretched federal law "by redefining key terms far beyond what Congress has permitted." Mot. 25. Specifically, Plaintiffs assert that the Final Rule unlawfully broadened the definitions of "health care entity," "assist in the performance," and "discriminate" or "discrimination." That is incorrect. The Rule's definitions of these terms fit comfortably within the bounds of the statutes the Rule implements.

Health Care Entity: The Coats-Snowe Amendment provides that "[t]he 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." 42 U.S.C. § 238n(c)(2) (emphasis added). Plaintiffs' contend that the Conscience Rule violates the APA because the definition of "health care entity" the Rules adopts "[f]or purpose of the Coats-Snowe Amendment," 84 Fed.

Reg. at 23,264, "includes nearly the entire health sector," Mot. 26. Plaintiffs assert that "Congress could not have intended the statute['s] text to include entire classes of entities distinct from those listed in the statutes." Mot. 26.[12] But "the term 'including' is not one of all-embracing definition, but connotes simply an illustrative application of the general principle." *Federal Land Bank of St. Paul v. Bismark Lumber Co.*, 314 U.S. 95, 100 (1941). As court after court has recognized, the term "includes" typically introduces a *non-exhaustive* list.[13] The Department's decision to provide a more expansive list of health care entities does not conflict with the broad definition in the statute.

Moreover, as the Department explained in response to comments raising these exact concerns, all three laws have catch-all provisions. *See* 84 Fed. Reg. at 23,194. The Coats-Snowe Amendment has a catch-all phrase for "any other program of training in the health professions," and the Weldon Amendment and ACA have catch-all provisions for "other health care professional[s]" and "any other kind of health care facility, organization, or plan." *Id.* The Rule's definition of "health care entity" is thus entirely consistent with the governing statutes. *See also* 84 Fed. Reg. at 23,194-95.

Assist in the Performance: The Final Rule defines "assist in the performance" to mean "tak[ing] an action that has a specific, reasonable, and articulable connection to furthering a procedure or a part of a health service program or research activity undertaken by or with another

---

[12] Plaintiffs similarly complain the although the Weldon Amendment and ACA define "health care entity" to "*include*[] an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan," Pub. L. No. 115-245 § 507(d)(2), 132 Stat. at 3118 (emphasis added); 42 U.S.C. § 18113(b), the definition of "health care entity" adopted for purposes of the Weldon Amendment and ACA includes "health plan sponsors and third party administrators," Mot. 26; *see* 84 Fed. Reg. at 23,264.

[13] *See, e.g.*, *Cobell v. Norton*, 240 F.3d 1081, 1100 (D.C. Cir. 2001) ("It is hornbook law that the use of the word including indicates that the specified list . . . that follows is illustrative, not exclusive."); *United States v. Wyatt*, 408 F.3d 1257, 1261 (9th Cir. 2005) ("The use of the word 'includes' suggests the list is non-exhaustive rather than exclusive.").

person or entity. This may include counseling, referral, training, or otherwise making arrangement for the procedure or a part of a health service program or research activity, depending on whether aid is provided by such actions." 84 Fed. Reg. at 23,263. Plaintiffs assert that this definition goes "far beyond what Congress provided." Mot. 27. It does not.

As Plaintiffs concede, none of the statutes implemented by the Conscience Rule defines the term "assist in the performance." Mot. 26-27. Plaintiffs nevertheless contend that the Rule's inclusion of "counseling" and "referrals" as protected actions are improper because the Church, Coats-Snowe, and Weldon Amendments "prohibit discrimination only on the basis of a refusal to 'perform' or 'assist in the performance' of a particular procedure." Mot. 27. The Department reasonably concluded, however, that counseling and referrals "are common and well understood forms of assistance that materially help people reach desired medical ends." 84 Fed. Reg. at 23,188.

As the Department explained, "because referrals are so tightly bound to the ultimate performance of medical procedures, Congress banned many forms of referral fees or 'kickbacks' among providers receiving Medicare and Medicaid reimbursements." *Id.* "Similarly, counseling of some form regarding abortion is often *required* before the procedure can be performed, as is the case in 33 States, and many hospitals and health care facilities likely require some kind of counseling as a prerequisite to abortion of their own accord." *Id.*

Plaintiffs also argue the Rule's definition is somehow "contrary" to the "common meaning" of the word "assist." Mot. 27. But the definition they provide—"to give support or aid"—hardly forecloses the Department's. The term "support" is just as elastic as the term "assist," and this Court should not grant the extraordinary remedy of a preliminary injunction based on mere wordplay.

Plaintiffs finally resort to legislative history, asserting that Senator Church's statements on the Senate floor foreclose the Department's definition of "assist in the performance." Mot. 28. But Plaintiffs misrepresent the legislative record. The statement Plaintiffs quote responded to a concern that the proposed amendment would allow an objecting doctor or a nurse to prevent a patient from obtaining an abortion or sterilization even if that doctor or nurse "had no responsibility, directly or indirectly, with regard to the performance of that procedure." 119 Cong. Rec. 9597 (Mar. 27, 1973) (statement of Senator Long); *see id.* (cautioning that the amendment could be understood "to say that where one seeks a sterilization procedure or an abortion, it could not be performed because there might be a nurse or an attendant *somewhere in the hospital* who objected to it.") (statement of Senator Long) (emphasis added). Senator Church was merely clarifying that the proposed amendment would not give religious healthcare professionals the power to veto procedures to which they objected. It merely gave them the right to personally opt out. The Rule's definition of "assist in the performance" is entirely consistent with Senator Church's views. *See* 84 Fed. Reg. at 23,192 (explaining that the definition of "discriminate" does not prevent an employer from "taking steps to use alternate staff or methods to provide for or further the objected-to conduct").

In all events, "statutory terms are generally interpreted in accordance with their ordinary meaning," and because "the statutory language is unambiguous," there is no need to consult legislative history to determine the meaning of the word "assist." *Sebelius v. Cloer*, 569 U.S. 369, 376, 380 (2013); *see also Lee v. Bankers Trust Co.*, 166 F.3d 540, 544 (2d Cir. 1999) ("It is axiomatic that the plain meaning of a statute controls its interpretation and that judicial review must end at the statute's unambiguous terms." (internal citations omitted)).

Discriminate or Discrimination: Plaintiffs contend that the Conscience Rule's definition

of "discriminates" "exceeds the boundaries set in the statute." Mot. 29. But they concede that none of the statutes the Rule implements define the term. Mot. 28. And Plaintiffs' proposed definition—the "failure to treat all persons equally when no reasonable distinction can be found between those favored and those not favored," Mot. 29—is consistent with the Rule's definition, which specifies the types of adverse conduct that cannot be imposed on account of a person's religious beliefs.

Plaintiffs contend that the definition "appears to require that Plaintiffs' health care entities hire someone who cannot deliver health care services that are critical to the entity's mission." Mot. 29. But the Rule specifically *allows* an employer to ask a prospective employee about his or her religious objections if there is a "persuasive justification" for the question. 84 Fed. Reg. at 23,263. If performing abortions is "critical" to an entity's "mission," the employer would certainly have a "persuasive justification" for asking prospective employees whether they have a religious objection to abortion.[14]

Nor does the Rule's definition of "discriminate" violate the Establishment Clause. *See infra* at 44-46. Contrary to Plaintiffs' assertion, the Rule expressly allows employers to offer "effective accommodations." 84 Fed. Reg. at 23,263. The Department explicitly "recognize[d] that staffing arrangements can be acceptable accommodations in certain circumstances." 84 Fed Reg. at 23,191 (the definition of "discriminate" "recognizes the effective and timely accommodation of an employee (which may include non-retaliatory staff rotations) as not constituting discrimination").

[14] The Rule also provides an exception to the general once-a-year limit on inquiring about religious beliefs where "there is a reasonable likelihood that the protected entity or individual may be asked in good faith to refer for, participate in, or assist in the performance of such conduct." 84 Fed. Reg. at 23,191.

Further demonstrating that accommodations are favored—not "prohibit[ed]," Mot. 29—the Department has promised to "take into account the degree to which an entity ha[s] implemented policies to provide effective accommodations" to religious healthcare professionals when "determining whether any entity has engaged in discriminatory action with respect to any complaint or compliance review." 84 Fed. Reg. at 23,263. Again, Plaintiffs have failed to show that the Conscience Rule exceeds the Department's statutory authorization.

2. The Conscience Rule is in accordance with law.

The Conscience Rule allows religious healthcare professionals to object to performing procedures that violate their religious beliefs. It also allows them to object to "counseling" about those procedures and "referr[ing]" patients for those procedures if "aid is provided by such actions." 84 Fed. Reg. at 23,263. Plaintiffs argue that these counseling and referral provisions violate the ACA, state disclosure laws, and the Emergency Medical Treatment and Labor Act ("EMTALA"). But they are wrong on all counts.

The ACA prohibits the Department from promulgating regulations that "violate[] the principals of informed consent and the ethical standards of health care professionals." 42 U.S.C. § 18114. But the Rule's counseling and referral provisions do not implicate ethical guidelines involving informed consent. As the American Medical Association ("AMA") recognizes, informed consent is required before a patient undergoes a "specific medical intervention." AMA Code of Medical Ethics § 2.1.1; *see Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2373 (2018) (informed-consent discussions are "tied to a procedure"). The Rule's counseling and referral provisions—which allow a healthcare professional to refrain from counseling a patient about an abortion procedure—have nothing to do with obtaining a patient's informed consent to undergoing a procedure.

Plaintiffs contend that the Rule contravenes medical ethics standards by allowing religious healthcare professionals to "refuse to provide information regarding lawful medical services"—by which they presumably mean abortion. Mot. 30. In support, they cite the AMA Code of Ethics, which deems it "ethically unacceptable" to withhold information without the patient's knowledge. Mot. 30-31. But the AMA's guidelines are not federal law.

CMDA, for example, publishes its own book on medical ethics and adheres to the Biblical Model of Medical Ethics. Stevens Decl. ¶ 8; Robert Orr and Fred Chay, *Medical Ethics: A Primer For Students* (2000); *see also Catholic Health Care Ethics*. And many doctors, including many CMDA members, reject as unethical interventions that either intentionally or actively end human life, including the unborn, the weak and vulnerable, and the terminally ill. *See* Stevens Decl. ¶¶ 16-19. Not too long ago, even the AMA agreed that no "physician, hospital, []or hospital personnel shall be required to perform *any act* violative of personally-held moral principles." *Roe v. Wade*, 410 U.S. 113, 143 n.38 (1973) (quoting AMA resolution) (emphasis added). Far from violating the ACA, as Plaintiffs argue, the Conscience Rule carries out the ACA's command by ensuring that religious healthcare professionals will not be forced to violate *their* ethical commitments.[15]

Plaintiffs also argue that the referral and counseling provisions "violate[] the ACA Non-Interference Mandate" by creating "unreasonable barriers" to healthcare and interfering with "communications regarding a full range of treatment options." Mot. 31-32 (citing 42 U.S.C.

[15] Dr. Frost and CMDA vigorously dispute Plaintiffs' assertion that abortion or euthanasia are *ever* "appropriate and medically-indicated." Mot. 31. Plaintiffs' contention that religious healthcare professionals are *ethically obligated* to provide information about abortion—a procedure that Dr. Frost and CMDA members could never perform without violating their most deeply held religious beliefs—only illustrates Plaintiffs' hostility to conscience rights and confirms the Rule's necessity. Indeed, the Supreme Court recently held that state laws requiring healthcare professionals to provide information about objected-to procedures, "regardless of whether a medical procedure is ever sought, offered, or performed," are unconstitutional. *Nat'l Inst. of Family & Life Advocates*, 138 S. Ct. at 2373.

§ 18114). But the Conscience Rule expressly permits providers to "inform the public of the availability of alternate staff or methods to provide or further the objected-to conduct." 84 Fed. Reg. at 23,263. And nothing in the ACA suggests that Congress meant to repeal long-standing conscience protections explicitly provided in the Church, Coats-Snow and Weldon Amendments. *See Epic Systems Corp. v. Lewis*, 138 S. Ct. 1612, 1624 (2018) (there is a "strong presumption that repeals by implication are 'disfavored' and that 'Congress will specifically address' preexisting law when it wishes to suspend its normal operations in a later statute.") (alterations in original omitted).

Plaintiffs further argue that the Rule "reduc[es] access to emergency care" in violation of EMTALA (Mot. 34), which requires hospitals with emergency departments to "provide for an appropriate medical screening … to determine whether or not an emergency medical condition … exists." 42 U.S.C. § 1395dd(a). If an emergency medical condition does exist, EMTALA requires the hospital to provide further treatment "to stabilize the medical condition." 42 U.S.C. § 1395dd(b)(1)(A). The hospital may "transfer . . . the individual to another medical facility" so long as the hospital "minimizes the risks to the individual's health and, in the case of a woman in labor, *the health of the unborn child*." 42 U.S.C. § 1395dd(b)-(c) (emphasis added).[16]

Plaintiffs speculate that the Conscience Rule could authorize an EMT or paramedic to violate EMTALA by leaving a woman requiring emergency treatment for an ectopic pregnancy on the curb. Mot. 33-34. As the Department explained, however, the Rule does not allow EMTs to deny transportation services if they merely *suspect* "that an objected-to service or procedure may occur." 84 Fed. Reg. at 23,188 (observing that there must be a "specific and reasonable connection

[16] To the extent Plaintiffs would have religious healthcare professionals perform or refer for abortions when a woman is in labor, it is Plaintiffs' policies that violate EMTALA. 42 U.S.C. § 1395dd(b)-(c).

between the objected-to service or procedure and the act of transporting the patient"). And there is scant reason to believe that any EMT or paramedic would have any religious objection to this type of transport.[17]

Plaintiffs finally contend that the Rule violates the Paperwork Reduction Act because the Department has not yet obtained approval for the collection requirements from the Office of Management and Budget (OMB). Mot. 35-36. At most, the delay in OMB authorization would justify preliminarily enjoining the certification requirement in § 88.4. But this concern will be moot if OMB approves the information collection requirements before the Rule's effective date.

3. The Conscience Rule is not arbitrary or capricious.

The Department adopted the Conscience Rule to address the significant "confusion" created by the 2011 Rule "over what is and is not required under Federal conscience and anti-discrimination laws." 84 Fed. Reg. at 23,175. As the Department explained, there was a "significant increase in complaints filed with OCR alleging violations of the laws that were the subject of the 2011 Rule, compared to the time period between the 2009 proposal to repeal the 2008 Rule and November 2016." *Id.* The Department also noted the proliferation of lawsuits filed against state and local laws on the ground that they "violate conscience or unlawfully discriminate." *Id.* at 23,176. These developments, and others documented in the Rule, convinced the Department of "the need for greater clarity concerning the scope and operation of the Federal conscience and anti-discrimination laws." *Id.* at 23,178. After receiving and evaluating comments from a broad range

[17] Plaintiffs cite Senator Weldon's statement that his proposed amendment was consistent with EMTALA, which prohibits "health facilities" from "abandon[ing] patients in medical emergencies." Mot. 34 (quoting 151 Cong. Rec. H176-77 (Jan. 25, 2005) (statement of Rep. Weldon)). But the Rule does not authorize hospitals or healthcare professionals to abandon patients. For the same reason, the Rule does not violate Section 1303 of the ACA, which provides that hospitals with emergency departments must "provid[e] emergency services as required by State or Federal law, including … EMTALA." 42 U.S.C. § 18023(d).

of perspectives, the Department made a reasoned decision to reinstate the substantive provisions of the 2008 Rule—including the certification requirement—and define certain key terms clarifying the rights and obligations of those subject to the rule.

Plaintiffs contend that the Department's decision should be set aside as arbitrary and capricious, Mot. at 36-44, but "[t]he scope of review under the 'arbitrary and capricious' standard is narrow and a court is not to substitute its judgment for that of the agency," *California v. Azar*, --F.3d --, 2019 WL 2529259, at *7 (9th Cir. June 20, 2019) (quoting *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983)).[18] Although Plaintiffs complain that the Department overlooked their evidence and overstated the expected benefits of the rule, their "arbitrary-and-capricious challenge boils down to a policy disagreement" with the Department that provides "no basis" for overturning the Rule. *Public Citizen, Inc. v. NHTSA*, 374 F.3d 1251, 1263 (D.C. Cir. 2004).

a. The Conscience Rule's definitions are not arbitrary and capricious.

Plaintiffs accuse the Department of "expand[ing] the reach of the underlying statutes through new definitions of statutory terms" that supposedly run "counter to the evidence" that such definitions "would dramatically undermine the safe and reliable provision of health care." Mot. 37. But Plaintiffs do not identify any evidence the Department overlooked, and the Department specifically responded to comments suggesting that the "Final Rule's expansion of the underlying statutes . . . would disrupt Plaintiffs' effective delivery of health care services to their residents." Mot. 37-38. As the Department explained, there was "no empirical data . . . on how previous

[18] Plaintiffs rely heavily on the district court's decision in *California v. Azar*, 2019 WL 1877392 (N.D. Cal. Apr. 26, 2019), one of several decisions that preliminarily enjoined a different HHS Rule. But the Ninth Circuit recently stayed those preliminary injunctions because the district courts there—like Plaintiffs here—"ignored HHS's explanations, reasoning, and predictions whenever they disagreed with the policy conclusions that flowed therefrom." *California v. Azar*, --F.3d--, 2019 WL 2529259, at *7.

legislative or regulatory actions to protect conscience rights have affected access to care or health outcomes." 84 Fed. Reg. at 23,180. Nor was the Department "aware of data to determine how many [religious healthcare] providers would exercise their conscience rights and protections once this rule is finalized." *Id.* And "[s]tudies have specifically found that there is insufficient evidence to conclude that conscience protections have negative effects on access to care." *Id.*

If contrary data or studies exist, Plaintiffs do not disclose them. Instead, they point to comments from officials in New York and California speculating about the possible effects of the Conscience Rule. Mot. 38 n.28. For example, the comments submitted by Attorneys General of several states (most of them Plaintiffs here), admitted that "[i]t is difficult to estimate the immense scope of administrative difficulty that this definition [of "assist in the performance"] could cause at facilities nationwide." ECF No. 43-53 at 7 (cited at Mot. 38 n.28). The Department's "disagree[ment] with the *assumption* that the rule's enforcement of Federal conscience and anti-discrimination laws will result in harm," 84 Fed. Reg. at 23,182 (emphasis added), does not make the Rule arbitrary and capricious. The Department was required only to "use[] the evidence before it to make a reasonable prediction about the likely present and future effects" of the Conscience Rule—which is precisely what it did. *Nat'l Cable & Telecomms. Ass'n v. FCC*, 567 F.3d 659, 669 (D.C. Cir. 2009).

Plaintiffs also contend that the Conscience Rule is arbitrary because its "full scope is vague and impossible to discern." Mot. 38 (noting that the definition of "assist in the performance" means an action with any "articulable connection" to furthering objectionable procedures). But the Department was not obligated to spell out in detail each action protected by the Conscience Rule—nor could it have done so. Whether a religious healthcare professional can be disciplined, consistent with the Rule, for refusing to perform any particular job duty will necessarily turn on

the "facts and circumstances of each case." 84 Fed. Reg. at 23,187. Moreover, in response to commenters' concerns, the Department modified the definition of "assist in the performance" to ensure that the "any articulable connection must also be 'reasonable' and 'specific.'" *Id.* The definition was thus fine-tuned to "preclude vague or attenuated allegations that do not support a claim of assisting in the procedure or health service program or research activity." *Id.*

b. The Department's cost-benefit analysis was not arbitrary and capricious.

As required by law, the Department calculated the number of entities subject to the Rule's regulations and projected the costs of complying with the Rule. 84 Fed. Reg. at 23,226-46. The Department concluded the Conscience Rule would "produce a net increase in access to health care, improve the quality of care that patients receive, and secure societal goods that extend beyond health care." *Id.* at 23,246; *see also id.* at 23,246-50 (describing benefits to healthcare professionals and organizations, patients, and society). This analysis, based on the data at hand, fully satisfied the Department's obligation to consider "important aspect[s] of the problem" and offer a reasoned explanation. *State Farm Mut. Auto. Ins. Co.*, 463 U.S. at 43.

Plaintiffs contend that the Department disregarded "extensive costs detailed in the record," and failed to "quantify the costs of the Final Rule on critical concerns, including the impact on access to care." Mot. 38. But the Department did not *ignore* the various comments alleging that the Rule "would drastically reduce access to health care, especially for vulnerable populations." Mot. 39; *see also* Mot. 39 n.29 (citing comments). Instead, the Department deemed the comments about the Rule's potential impact on healthcare too speculative to use in a cost-benefit analysis. 84 Fed. Reg. at 23,182. Although the Department recognized the dearth of data "establishing quantitatively how much the rule will increase and enhance access to health care services in underserved communities," it was also "not aware of data establishing the views of commenters who

sa[id] the rule w[ould] reduce services in underserved communities." *Id*. It therefore concluded that it was "reasonable to agree with commenters who believe the rule will not decrease access to care, and may increase it." *Id.* Plaintiffs may *disagree* with the Department's conclusions, but they cannot credibly claim that the Department "declined to assess the Final Rule's impact on access to health care services." Mot. 39.[19]

Plaintiffs also contend that there was insufficient evidence in the record to support the Department's conclusion that "faith-based health care providers would likely limit the scope of their medical practice if conscience rules were not in place." Mot. 40. The Department based that conclusion, in part, on a 2009 survey conducted by the Christian Medical Association finding that religious healthcare professionals would likely be forced to leave the practice of medicine absent the protections afforded by the Conscience Rule. 84 Fed. Reg. at 23,246-47. Plaintiffs do not find fault with that survey's methodology or conclusions. Instead, they criticize the Department for failing to determine whether the rescission of the 2008 rule three years later had "any effect on the scope of practice of faith-based professionals." Mot. 40. The Department did, however, document the increase in complaints filed over the past three years, which evidence strongly suggested that the concerns highlighted in the survey were materializing. 84 Fed. Reg. at 23,175-79. The Department's conclusion that the Rule would expand healthcare by allowing religious healthcare professionals to stay in their practices is entirely reasonable.

[19] Plaintiffs contend that the Department ignored comments providing "specific evidence describing numerous methodological approaches the Department could have used to estimate the[] impacts" of the Rule on access to care. Mot. 40 n.30. The single comment they cite, however, does not purport to provide a methodology. *See* ECF No. 43-58 (Comment Letter from Institute for Policy Integrity). Nor have Plaintiffs identified comments providing "quantitative and qualitative evidence of the impact religious refusals have on access to care." Mot. 40 n.30. The comments Plaintiffs cite provide little more than speculation about the Rule's potential costs. *See* Mot. 39 n.29.

Plaintiffs contend that the comment the Department cited does not support its conclusion "a certain proportion of decisions by currently practicing health providers to leave the profession are motivated by coercion or discrimination based on providers' religious beliefs or moral convictions." Mot. 41 (citing 84 Fed. Reg. at 23,247 & n.322). But that conclusion was only incidental to the Rule—it was not the basis for it. *Cf. City of Los Angeles v. Sessions*, 293 F. Supp. 3d 1087, 1099-1100 (C.D. Cal. 2018) (agency action is arbitrary and capricious where "there is no evidence of record . . . that [the agency] *based [its] conclusion* on any findings or data" (emphasis added)) (cited at Mot. 41). Moreover, the Department candidly admitted that it lacked "data enabling it to quantify any effect the rule may have on increasing the number of health care providers or the possible result of increasing access to care." 84 Fed. Reg. at 23,247. Plaintiffs present no evidence suggesting that it was unreasonable for the Department to believe that the Rule would "engender more people to be willing to enter the health care profession" by "remov[ing] a barrier to entry." *Id.*

Relying on the now-stayed district court opinion in *California*, Plaintiffs assert that the Department failed to cite evidence supporting its conclusion that the rule would "ensure knowledge of, compliance with, and enforcement of" the underlying statutes. Mot. 41 (citing *California*, 2019 WL 1877329, at *41). But the Department hardly needed to conduct a study to conclude that a rule requiring health care entities to certify their understanding of federal conscience protections would have the effect of ensuring knowledge of federal conscience protections. And Plaintiffs' irreparable-harm allegation *presumes* that the enforcement provisions of the Conscience Rule will be more rigorous than the toothless complaint mechanism put in place by the 2011 Rule.

Plaintiffs accuse the Department of understating the costs of compliance because the "number of covered entities" under the Conscience Rule are purportedly "far larger than the Department's estimate," given the "expansion of the term 'health care entity.'" Mot. 41-42. But as the Department explained in response to the same comments Plaintiffs cite, "[t]he term 'health care entity' is used . . . to specify not which entity must comply with the statute, but which kinds of entities are *protected from discrimination*." *Id.* at 23,195 (emphasis added). "Thus, including an entity in the term 'health care entity' under those statutes does not expand or affect which governmental or non-governmental fund recipients must comply with those statutes." *Id.* Plaintiffs cannot manufacture an APA challenge based on a misreading of the Rule.

Nor is there anything "fanciful" about the Department's estimate that covered entities or persons could "familiarize themselves with the Final Rule" and its compliance requirements in a short period of time. Mot. 42. Even though the entire Rule is "113,000 words in length," Mot. 42 n.34, the substantive provisions of the Rule comprise only a few sections, and any given employer is subject to only a handful of specific provisions.

In sum, Plaintiffs improperly seek to invalidate the Rule based on their disagreement with the Department's weighing of the evidence. But agency action is not arbitrary and capricious merely because a reasonable person could have reached a different conclusion—an agency need only "weigh[] competing views," select an approach "with adequate support in the record," and "intelligibly explain[] the reasons for making that choice." *FERC v. Elec. Power Supply Ass'n*, 136 S. Ct. 760, 784 (2016). That is precisely what the Department did here.

c. The assurance and certification requirements do not violate the APA.

Plaintiffs contend that the written certification requirement is arbitrary and capricious because the Final Rule does not acknowledge "the Department's own prior position that this precise

collection of information is unnecessary and burdensome." Mot. 43. But the Department specifically noted that the 2011 Rule rescinded the notification requirement in section 88.5 of the 2008 Rule, 84 Fed. Reg. at 23,174, and concluded that the 2011 Rule "created confusion over what is and is not required under Federal conscience and anti-discrimination laws," *id*. at 23,175. The Department unambiguously conveyed its disagreement with the 2011 Rule's conclusion that the certification requirements were "unnecessary." 76 Fed. Reg. at 9,974. Because the Department did not abandon its "prior policy *sub silentio*," but rather offered "good reasons for [its] new policy," the Rule is not arbitrary or capricious. *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009).

4. The Conscience Rule does not violate the Separation of Powers.

Plaintiffs accuse the Department of "rewrit[ing] the statutes Congress enacted," Mot. 45, but this is just a repackaged version of their flawed APA arguments and should be rejected for the same reasons. Moreover, although Plaintiffs contend that the Rule gives the Department unlawful power "to refuse to spend funds Congress appropriated," Mot. 45, they concede that the statutes at the Department implements place "conditions on the receipt of federal funds that relate to religious or moral refusals to provide healthcare," Mot. 44. Because the Conscience Rule "does not create substantive protections beyond those in existing law," 84 Fed. Reg. at 23,247, but simply enforces longstanding federal statutes that condition federal funds on the protection of conscience rights, it poses no threat to the separation of powers.

5. The Conscience Rule does not violate the Spending Clause.

The Spending Clause generally allows the federal government to "attach conditions to the receipt of federal funds . . . to further broad policy objectives." *South Dakota v. Dole*, 483 U.S. 203, 206 (1987). When the federal government attaches conditions on funding to the States, it must do so "unambiguously," in a manner that is sufficiently related to the federal program at

issue, without coercion, and without requiring the States to violate the federal constitution. *Id.* at 207-08, 211. Plaintiffs argue that the Conscience Rule fails each of these elements. Not so.

a. The Conscience Rule is not ambiguous.

Plaintiffs' lead argument is that the Conscience Rule retroactively imposes conditions on the receipt of federal funds that were not sufficiently "unambiguous" at the time they accepted the money. Mot. 47-50. But "the substantive requirements" enforced by the Conscience Rule "were set forth by Congress," often in "laws [that] have existed for decades." 84 Fed. Reg. at 23,222; *see e.g.*, Pub. L. 93-45, Title IV § 401, 87 Stat. 91, 95 (1973) (enacting initial Church Amendment 46 years ago). The Department was "not aware of any successful Spending Clause challenges" to these underlying laws, 84 Fed. Reg. at 23,222, and Plaintiffs have not identified any such cases. Indeed, Plaintiffs do not dispute that they had clear notice of the longstanding substantive requirements underlying the Conscience Rule. Because they have accepted billions in federal funds subject to the conditions imposed by these federal statutes, Plaintiffs cannot (and do not) plausibly claim that those substantive agreements were unclear or unfair. Instead, they nitpick at the margins about slightly expanded definitions and more muscular enforcement guidelines (which only bring conscience protections on parity with other HHS civil rights enforcement).

Plaintiffs argue that the Conscience Rule "alter[s] the conditions to which [they] initially agreed' by "includ[ing] new definitions . . . that dramatically expand the scope of those statutes," Mot. 47, but that argument fails for the reasons stated above. *See supra* at 25-30. Nor does that argument rise to the level of a Spending Clause violation. Plaintiffs are not claiming that they were unaware that federal law protected rights of conscience for doctors, but merely that they did not know the law also protected the same rights for other healthcare professionals, such as EMTs. At most, that kind of clarification "merely altered and expanded the boundaries of the [protected] categories"—it did not "transform[]" the relevant programs through which Plaintiffs receive

federal funds. *Nat'l Fed. of Indep. Bus. v. Sebelius*, 567 U.S. 519, 583 (2012) (*NFIB*). Because extending conscience protections to EMTs does not "accomplish[] a shift in kind," but "merely degree," the Conscience Rule does not violate the Spending Clause. *Id*. at 583. Moreover, Plaintiffs were on notice that such minor alterations were part of the deal that they accepted for many of the underlying federal statutes. *See*, *e.g.*, 42 U.S.C. § 1304 (reserving the "right to alter, amend, or repeal any provision of this chapter").

Similarly, Plaintiffs complain that the Conscience Rule subjects them to "OCR's enforcement process" and related record-keeping requirements. Mot. 47. But any enforcement "will be conducted *in the same way* that OCR implements other civil rights requirements (such as the prohibition of discrimination on the basis of race, color, or national origin)." 84 Fed. Reg. at 23,179-80 (emphasis supplied), *id.* at 23,257 (noting that the Conscience Rule "relies on enforcement mechanisms already available to HHS for grants and other forms of financial assistance"); *see*, *e.g.*, 45 C.F.R. § 91.31 *et seq.* (setting similar compliance and information requirements for HHS funding recipients in the age discrimination context). Plaintiffs offer no reason to think that following the same rules for statutorily protected conscience rights "so dramatically" changes the law that it effectuates "a new . . . program." *NFIB*, 567 U.S. at 584. Nor do they explain how their arguments would leave similar federal regulations effectuating enforcement of Title VI and Title IX unscathed. *See* 45 C.F.R § 80 (Title VI); 45 C.F.R. § 86 (Title IX).

Next, Plaintiffs argue they do not have clear notice of the Rule's requirements because the Conscience Rule allows consideration of the "facts and circumstances" of any potential violation. Mot. 48-49. But faithfully applying that argument would require revisiting over 1,500 federal regulations that use the same "facts and circumstances" formulation. Not surprisingly, Plaintiffs

fail to identify a single case accepting that position. Indeed, they contradict their own argument when they later complain that the Conscience Rule is too rigid. *Id.* at 53 (arguing that the Rule fails to allow consideration of "secular interests or the conflicting religious beliefs of other employees or patients").

Plaintiffs wrap up their argument with the contention that § 88.7 gives the Department too much latitude over which funds it can withdraw. But nothing in the Conscience Rule commits the Department to withdrawing any funding other than what the underlying federal laws would permit. 84 Fed. Reg. at 23,223. To the contrary, the regulations state that the Department must "interpret and apply the remedies that § 88.7 sets forth in a manner consistent with the particular Federal law(s) at issue." 84 Fed. Reg. at 23,256. In any event, the most this argument would get Plaintiffs is a reduction in the *amount* of funding withdrawn, not avoidance of *any* withholding or invalidation of the Conscience Rule entirely. *NFIB*, 567 U.S. at 585 (conditions valid on new funding, just not on the entirety of existing funding); *see also* 84 Fed. Reg. at 23,272 (§ 88.10) (severability clause).

b. The Conscience Rule is neither coercive nor unrelated to the Congressional enactments it enforces.

Plaintiffs turn next to coercion, arguing that the Conscience Rule "is a gun to the head." Mot. 51. It is no such thing. Actions speak louder than lawsuits, and if the substantive provisions of the Conscience Rule are a gun, the States have been comfortable staring down it for decades, because the Conscience Rule merely enforces longstanding federal statutes that the States have never bestirred themselves to challenge, while receiving billions of dollars in federal funds.

Plaintiffs contend that the Conscience Rule violates the Spending Clause's "nexus" requirement because it threatens "all federal funds" provided through the 2019 appropriations law. Mot. 52. But that argument should be directed to the Weldon Amendment, not the Conscience

Rule, because the Weldon Amendment expressly provides that "[n]one of the funds made available *in this Act* may be made available to a Federal agency or program" that discriminates against an individual or health care entity on the basis that it will not provide, pay for, provide coverage of, or refer for abortions." *Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019*, Pub. L. No. 115-245 § 507(d)(1), 132 Stat. 2981, 3118 (emphasis added). Enjoining the Conscience Rule will not narrow the scope of the funding condition imposed by the Weldon Amendment.

c. The Conscience Rule does not require the States to violate the Establishment Clause.

Finally, Plaintiffs argue that the Conscience Rule forces them to "accommodate their employees' religious beliefs to the exclusion of all secular interests," in violation of the Establishment Clause. Mot. 53 (citing *Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703 (1985)). The Conscience Rule does no such thing. Rather, it provides the States ample leeway to pursue their interests while protecting conscience rights.

In all events, *Caldor* does not provide the proper framework for analyzing a potential Establishment Clause violation. As the Supreme Court recently reiterated, "the Establishment Clause *must* be interpreted 'by reference to historical practices and understandings.'" *American Legion v. American Humanist Assoc.*, ---S. Ct.---, 2019 WL 2527471, at *16 (2019) (quoting *Town of Greece v. Galloway*, 572 U.S. 565, 576 (2014)) (emphasis added). Religious accommodations for both religious organizations and individuals "fit[] within the tradition long followed" in our nation's history. *Id*. at 577 (quoting *Town of Greece*, 572 U.S. at 577); *see also Hosanna-Tabor Evangelical Lutheran Church and School v. EEOC*, 565 U.S. 171, 189 (2012) ("the First Amendment itself . . . gives special solicitude to the rights of religious organizations"); *Trinity Lutheran Church of Columbia, Inc. v. Comer*, 137 S. Ct. 2012, 2019 (2017) ("religious observers"

accommodated).

Indeed, the historical understanding of the Establishment Clause often *requires* broad religious exemptions. In *Hosanna-Tabor*, a unanimous Supreme Court held that historical anti-establishment interests required that churches be wholly exempt from employment discrimination laws with regard to their ministerial employees. 565 U.S. 171. Such religious accommodations are not just permissible under the Establishment Clause, they "follow[] the best of our traditions." *Zorach v. Clauson*, 343 U.S. 306, 314 (1952).

Here, Plaintiffs make no attempt to reconcile their Establishment Clause argument with the historical protections afforded to conscience rights. Nor do they explain why the Church, Coats-Snowe, and Weldon Amendments would not themselves run afoul of the Establishment Clause under their view.

Moreover, the Supreme Court has squarely rejected Plaintiffs' reading of *Caldor* and held that religious accommodations can be valid even when they "substantially burden third parties." Mot. 53. In *Corp. of Presiding Bishop of The Church of Jesus Christ of Latter-day Saints v. Amos*, 483 U.S. 327 (1987), the Court addressed a challenge to a federal employment law that generally prohibited employment discrimination on the basis of religion, but which granted an exemption to religious organizations by allowing them to hire and fire on the basis of religion. The plaintiff argued that the exemption violated the Establishment Clause, in part because it "necessarily has the effect of burdening . . . prospective and current employees." *Id.* at 340 (Brennan, J., concurring in the judgment). And in fact, the exemption imposed a substantial burden on the plaintiff, who had been terminated on the basis of religion—an adverse employment action that would have been unlawful but for the religious accommodation. Nevertheless, the Supreme Court unanimously upheld the religious exemption, concluding it was permissible to "lift[] a regulation that burdens

the exercise of religion." *Id.* at 338. So too here: the Conscience Rule lifts any conflicting State or federal regulations that burden the conscience rights of CMDA members and other religious healthcare professionals.[20]

IV. CONCLUSION

For the foregoing reasons, Plaintiffs' motion for a preliminary injunction should be denied.

[20] The idea that religious accommodations are impermissible whenever they create third-party burdens has often been used to mask hostility to religion. Religious ceremonies have been banned by cities under the guise of public health. *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 544-45 (1993). The construction of mosques has been challenged on the ground that they pose "elevated risks to the public safety." *United States v. Rutherford Cty. Tenn.*, 2012 WL 3775980, at *2 (M.D. Tenn. Aug. 29, 2012). Gurdwaras have been excluded because they create traffic burdens in populated areas, and conversely because they create development burdens in rural ones. *Guru Nanak Sikh Soc. of Yuba City v. Cty. of Sutter*, 456 F.3d 978, 990 (9th Cir. 2006).

Dated: June 28, 2019

New York, New York

Respectfully submitted,

GIBSON, DUNN & CRUTCHER LLP

/s/ Allyson N. Ho

Daniel Blomberg (*pro hac vice forthcoming*)
Nicholas Reaves (*pro hac vice forthcoming*)
THE BECKET FUND FOR RELIGIOUS LIBERTY
1200 New Hampshire Ave. NW, Suite 700
Washington, D.C. 20036
Telephone: 202.955.0095
Facsimile: 202.955.0090

Allyson N. Ho (*pro hac vice*)
GIBSON, DUNN & CRUTCHER LLP
2100 McKinney Avenue, Suite 1100
Dallas, Texas 75201
Telephone: 214.698.3100
Facsimile: 214.571.2900

Robert E. Dunn (*pro hac vice forthcoming*)
GIBSON, DUNN & CRUTCHER LLP
1811 Page Mill Road
Palo Alto, California 94304
Telephone: 650.849.5300
Facsimile: 650.849.5333

Jason H. Hilborn (*pro hac vice forthcoming*)
GIBSON, DUNN & CRUTCHER LLP
1050 Connecticut Avenue, N.W.
Washington, DC 20036
Telephone: 202.955.8500
Facsimile: 202.467.0539

Attorneys for Amici (and Proposed Intervenors) DR. REGINA FROST AND CHRISTIAN MEDICAL AND DENTAL ASSOCIATIONS

Exhibit B

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, et al., Plaintiffs, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	No. 1:19-cv-4676 (PAE) No. 1:19-cv-5433 (PAE) No. 1:19-cv-5435 (PAE)

DECLARATION OF DAVID STEVENS, M.D., M.A., IN SUPPORT OF OPPOSITION TO MOTION FOR PRELIMINARY INJUNCTION

1. I, David Stevens, pursuant to 28 U.S.C. § 1746, hereby declare that the following is true and correct:

2. I submit this Declaration in support of Defendant-Intervenors Dr. Regina Frost and Christian Medical and Dental Associations' ("CMDA") Opposition to Motion for Preliminary Injunction. I have personal knowledge of the facts set forth herein and if called upon to do so, would testify competently thereto under oath. I have familiarized myself with the recently issued rule entitled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority" ("Final Rule"), to understand its immediate impact upon CMDA and its members.

3. I am a physician and the Chief Executive Officer ("CEO") of CMDA, a position I have held for nearly 25 years. Prior to joining CMDA, I was the Director of World Medical Missions, the medical arm of Samaritan's Purse.

4. Consistent with CMDA's commitment to serving all people with dignity and compassion, I have spent considerable time overseas serving those with little to no access to medical care. Much of this work involved significant personal costs and physical danger. For example:

- From 1981 to 1991, I served in a rural hospital in Kenya that was the only source of healthcare for half a million people. During this time I was Medical Superintendent and then CEO. I was involved in developing the hospital from a "bush hospital" to a 250-bed tertiary center, started a nursing school, a laboratory training school and a large public health program.
- I led a relief team of physicians in Mogadishu, Somalia that treated over 45,000 patients in the midst of a civil conflict and famine in that country.
- I led a medical relief team in Sudan that treated over 25,000 patients and wiped out a deadly epidemic of relapsing fever that had a 50% mortality rate. The country was in the midst of a civil war while we were there, and our team was kidnapped and held hostage for a number of days.
- I supervised the first medical relief team to enter Kigali, Rwanda in 1994, which opened the main hospital in the midst of the genocide in which over a million people were slaughtered .

- I have led medical teams into prisons with deplorable conditions and little to no medical care in Zambia, Peru, and Ecuador.

- I have led medical teams on trips to the Philippines (tsunami relief), Nicaragua (caring for victims of human trafficking) and to Honduras, and Kenya to take care of the poor.

5. In my long medical career, I have treated all patients without discriminating on the basis of race, religion, nationality, sexual orientation, or gender.

6. CMDA was founded in 1931. It educates and equips its nearly 20,000 members to glorify God by fulfilling His Great Commandment and His Great Commission. CMDA members are committed to fulfilling Christ's command to "love your neighbor as yourself." *Matthew* 22:39 (English Standard Version). CMDA encourages its members to take an oath to "love those who come to [them] for healing and comfort" and to "car[e] for the lonely, the poor, the suffering, and the dying."

7. As a Christian organization, CMDA has published over seventy position statements concerning various medical, scientific, ethical and public policy issues. These position statements are informed by CMDA's Christian religious beliefs.

8. For example, CMDA has official position statements regarding—among other things—Abortion, AIDS, the Biblical Model for Medical Ethics, Death, Eugenics and Enhancement, Euthanasia, Healthcare Right of Conscience, Human Life: Its Moral Worth, Human Trafficking, Parental Rights, Patient Refusal of Therapy, Physician-Assisted Suicide, and Sharing Faith in Practice.

9. CMDA has long advocated for legislative and regulatory action to protect conscience rights. CMDA has an official position statement on Healthcare Right of Conscience, which states:

> Respect for conscientiously held beliefs of individuals and for individual differences is an essential part of our free society. The right of choice is foundational in

> our healthcare process, and it applies to both healthcare professionals and patients alike. Issues of conscience arise when some aspect of medical care is in conflict with the personal beliefs and values of the patient or the healthcare professional. CMDA believes that in such circumstances the Rights of Conscience have priority.

10. CMDA also has an official position statement on The Healthcare Professional's Right of Conscience, which states:

> All healthcare professionals have the right to refuse to participate in situations or procedures that they believe to be morally wrong and/or harmful to the patient or others. In such circumstances, healthcare professionals have an obligation to ensure that the patient's records are transferred to the healthcare professional of the patient's choice."

11. CMDA encourages its members to treat all patients. For example, CMDA's official position statement on LGBT patients states, *inter alia*:

> "Because we are guided by Christ, who assisted all who sought his help regardless of sexual or social status, CMDA affirms the obligations of Christian healthcare professionals to care for all patients in need, regardless of sexual orientation, gender identification, or family makeup, with sensitivity and compassion[.] . . . Christian healthcare professionals, in particular, must care for their same-sex-attracted patients in a non-judgmental and compassionate manner, consistent with the humility Jesus modeled and the love Jesus commanded us to show all people."

12. Similarly, CMDA's official position statement on AIDS states:

> "Acquired immunodeficiency syndrome (AIDS) caused by the human immunodeficiency virus (HIV) is a growing epidemic that may surpass the ravages of any plague in human history. We extend compassion to all who have acquired this disease by whatever means. We urge the provision of medical care for them to the same degree that patients with other life-threatening diseases receive it. Christian physicians and dentists, following the example of Christ, should care for HIV-infected persons even at the risk of their own lives. We encourage all healthcare workers to do the same."

13. CMDA also believes that physicians should not hinder the continuity of care, even when they object to a particular procedure. For example, CMDA's position statement on Vegetative States provides that "[i]f a physician, because of moral convictions, is unable to comply with the patient's or surrogate's wishes to withhold or withdraw artificially administered nu-

trition and hydration, it is appropriate for the physician to withdraw from the care of the patient as soon as another physician assumes that care."

14. In furtherance of its mission to care for all people, CMDA partners with Christian Community Health Fellowshp (CCHF) which encourages, engages and equips healthcare professionals to serve the poor and marginalized. CCHF works with 156 clinics in the United States that focus on serving the neediest members of society, including the uninsured, immigrants, and children.

15. CMDA also operates a short-term medical relief program that conducted 45 one- to two-week service projects in 2018, with 1,041 participants (physicians, dentists, nurses) traveling to Central and South America, the Caribbean, the Middle East, Asia, and Africa. Program participants served 60,060 patients without regard to race, religion, gender, sexual orientation, socio-economic status, or any other factor. Program participants paid their own way and helped to cover the cost of medicines and supplies.

16. CMDA conducted a survey of its members in 2014, and 55.4% of respondents reported that they offer free or steeply discounted care for the poor.

17. Although CMDA believes that healthcare providers should treat all patients, it holds that certain procedures—including abortion and euthanasia—are incompatible with the Christian faith.

18. CMDA's official position on euthanasia states:

> We, as Christian physicians and dentists, believe that human life is a gift from God and is sacred because it bears His image. The role of the physician is to affirm human life, relieve suffering, and give compassionate, competent care as long as the patient lives.

19. Some of CMDA's members have religious objections to other procedures, including sterilization and artificial contraception.

20. CMDA does not have any official policy addressing the ethics of treating an ectopic pregnancy. CMDA understands that the standard of care for treating an ectopic pregnancy is to remove the embryo from the fallopian tubes. Because this procedure is aimed at protecting the health of the mother, and because an embryo cannot survive in the fallopian tubes, CMDA does not have a religious objection to the standard treatment for ectopic pregnancies. Ectopic pregnancies sometimes rupture, a dangerous situation that can result in hemorrhaging. CMDA understands that the standard of care for a ruptured ectopic pregnancy is to remove the embryo—if it is still attached to the fallopian tube—and surgically repair the fallopian tube. Because this procedure is aimed at protecting the health of the mother, and because an embryo cannot survive a ruptured ectopic pregnancy, CMDA does not have a religious objection to the standard of care for treating a ruptured ectopic pregnancy.

21. CMDA recognizes that miscarriages are an unfortunate fact of life. In some cases, a woman who has suffered a miscarriage may need medical intervention to remove the fetal tissue to prevent infection. Because this procedure is aimed at protecting the health of the mother and does not terminate a human life, CMDA has no religious objection to this procedure for treating miscarriages.

22. CMDA does not agree with all of the ethics guidelines adopted by the American Medical Association ("AMA"). In particular, CMDA does not believe that the AMA's guidelines adequately protect the right of conscience. The AMA's Code of Medical Opinion 1.1.7, Physician Exercise of Conscience, is particularly deficient, as it would impose an obligation on doctors to perform procedures against their religious beliefs when there is a risk even to the patient's "emotional well-being." CMDA does not believe that physicians should ever be required to perform procedures that violate their firmly held religious beliefs.

I declare under penalty of perjury that, to the best of my knowledge, the foregoing is true and correct.

Executed on this 28 day of June, 2019.

David Stevens

CEO, Christian Medical and Dental Associations

Exhibit C

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, et al., Plaintiffs, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	No. 1:19-cv-4676 (PAE) No. 1:19-cv-5433 (PAE) No. 1:19-cv-5435 (PAE)

DECLARATION OF REGINA RENEE FROST, M.D.,
IN SUPPORT OF OPPOSITION TO MOTION FOR PRELIMINARY INJUNCTION

1. I, Dr. Regina Renee Frost, pursuant to 28 U.S.C. § 1746, hereby declare that the following is true and correct:

2. I submit this Declaration in support of Proposed Intervenors' Opposition to Plaintiffs' Motion for Preliminary Injunction. I have personal knowledge of the facts set forth herein and if called upon to do so, would testify competently thereto under oath.

3. I graduated from the University of Michigan with a BA in Psychology in 2000. I graduated from Wayne State University School of Medicine in 2004. I was an Obstetrics and Gynecology Resident at St. John Hospital and Medical Center in Detroit, Michigan from 2004 to 2008. During my last year of residency I was the Chief Administrative Resident.

4. From 2008 to 2009 I worked in private practice as an OBGYN at the Medical Resources Group. From 2010 to 2013 I was part-time faculty at St. John Hospital and Medical Center. From 2010 to 2017 I was a solo-practitioner operating Compassionate Women's Healthcare. From 2018 to the present I have worked at St. John ObGyn Associates with the Ascension Medical Group. I served as a Clinical Assistant Professor for Michigan State University in the Department of Osteopathic Surgical Specialties from 2011 to 2017.

5. I am a Christian and have been a member of the Christian Medical Association since 2014.

6. My Christian faith has given me a passion for missions and helping those in need. For example, during medical school, I served on a mobile medical team in Nyahururu, Kenya, attending to the needs of women, children, and the elderly. I pray with my patients when appropriate and offer words of encouragement to lift their spirits.

7. I have helped lead Women Physicians in Christ ("WPC"), a ministry of CMDA, since 2014. The mission of WPC is to build relationships among female physicians so that they

can encourage and support one another in the profession. I lead a Bible study for a local WPC group that I started in 2014.

8. My work as an OBGYN, my service to those in need, and my leadership of a ministry to women physicians all flow directly from my Christian faith. *See 1 Corinthians* 10:31 ("So whether you eat or drink or whatever you do, do it all for the glory of God."). I sincerely believe that Christians should feed the hungry, give water to the thirsty, provide homes to strangers, clothe the needy, care for the sick, and visit prisoners. *Matthew* 25:31-46. By serving others, we serve and honor God. *Id.* ("Truly I tell you, whatever you did for one of the least of these brothers and sisters of mine, you did for me."). I believe that God is just as interested in what I do to serve others, including as a doctor, as He is in what I do on Sunday mornings at church. *Isaiah* 58:1-12 ("Is this not the kind of fasting that I have chosen: to loose the chains of injustice and untie the cords of the yoke, to set the oppressed free and to break every yoke?").

9. I am committed to treating every patient with dignity and love, without regard to race, religion, sexual orientiation, or gender. That is because I believe that every person is created in the image of God, and possesses inherent dignity. *Genesis* 1:27 ("God created man in his own image."). And Christ commands us to love our neighbor as ourselves. *Matthew* 22:39.

10. As a Christian, I have religious objections to providing or participating in certain procedures, including abortion and sex reassignment surgery, which I believe to be contrary to God's will and inconsistent with my best medical judgment for my patients.

11. These religious objections are based on the teachings of my faith. I believe, for instance, that the unborn are persons created by God who deserve my respect. *See, e.g., Jeremiah* 1:4-5 ("'Before I formed you in the womb I knew you, and before you were born I consecrated you; I appointed you a prophet to the nations.'"); *Psalm* 139:13-16 (noting that God "formed

my inward parts . . . knitted me together in my mother's womb," and knew "the days that were formed for me, when as yet there was none of them"). I believe it would be wrong for me to personally participate in causing their death. *See*, *e.g.*, *Matthew* 5:21 and 19:18 (affirming the commandments against taking innocent human life).

12. Any patient who asks about abortion is informed that I do not perform that procedure. If my employer or the government ever directed or pressured me to perform a procedure to which I have a religious objection, I would be compelled to resign or to leave the practice of medicine, because I will not perform any procedure that my faith teaches is wrong or which I believe is not in the best interests of my patient.

13. I believe that the federal government should protect healthcare providers' conscience rights to ensure that no employer, or state or municipal government, can require healthcare professionals to perform or facilitate procedures to which they have sincere religious objections, or punish healthcare professionals for refusing to perform or facilitate such procedures. I have heard from several physicians who have been terminated or faced significant opposition because of their religious beliefs, and I am concerned that one day I too could be pressured to perform a medical procedure that I find morally objectionable. I am especially concerned about that in this case, given that my home state of Michigan is a plaintiff in this lawsuit. Without the conscience protections afforded by the regulation challenged in this lawsuit—*Protecting Statutory Conscience Rights in Health Care; Delegations of Authority*, 84 Fed. Reg. 23,170 (May 21, 2019) ("Conscience Rule")—I would likely be subject to discrimination or termination in such an instance on account of my religious beliefs. Invalidating the Conscience Rule would thus harm me and other healthcare professionals with religious objections to certain procedures.

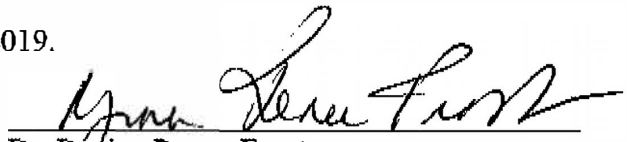
14. As an OBGYN, I have treated many women diagnosed with ectopic pregnancies, which describes a situation where the embryo implants in the Fallopian tube (or, less commonly, in other locations, such as the cervix or abdomen) rather than the uterus. Ectopic pregnancies are typically diagnosed within the first 4-8 weeks of pregnancy. Many ectopic pregnancies resolve naturally when the embryo detaches and is expelled from the body. However, ectopic pregnancies can cause the Fallopian tube to rupture, which results in hemorrhaging that can threaten the mother's life. Because of this risk, the standard of care for women diagnosed with an ectopic pregnancy is to remove the embryo. If it is diagnosed early and the patient is stable, an ectopic pregnancy can be treated medically by administering methotrexate, which avoids surgery and preserves the Fallopian tubes. If that is not an option, surgery is usually scheduled immediately after a woman is diagnosed, but the timing of the procedure is based on the operating room's availability and the patient's clinical status. Because this procedure is aimed at protecting the mother's health, and because an embryo cannot survive in the Fallopian tubes, I do not have a religious objection to this procedure. I have performed this procedure on many of my patients after diagnosing them with an ectopic pregnancy. I am not aware of any OBGYNs that have a religious objection to removing an ectoptic pregnancy, though I understand that there may be disagreements over the most appropriate type of treatment.

15. If an ectopic pregnancy ruptures, the standard of care is immediate surgery to remove the embryo—if it remains in place—and to surgically repair the ruptured Fallopian tube. Because a ruptured ectopic pregnancy is an emergency that endangers the life of the mother, and because the life of the embryo cannot be saved, I do not have a religious objection to this procedure. I have performed this procedure on my patients. I am not aware of any physician who has a religious objection to this procedure.

16. I have also treated many patients who have suffered from miscarriages. A miscarriage results in the death of the fetus by natural means. In most instances, a miscarriage will not require medical intervention because the fetal tissue will pass naturally. In some cases, however, the woman's body does not expel the fetal tissue, which puts her at risk of infection. The standard of care in this situation is a procedure to remove the fetal tissue. Because this procedure does not terminate a human life, and is aimed at protecting the mother's health, I do not have a religious objection to it. I have performed this procedure on many of my patients. I am not aware of any OBGYNs who have religious objections to treating a woman who has suffered a miscarriage.

I declare under penalty of perjury that, to the best of my knowledge, the foregoing is true and correct.

Executed on this 28th day of June, 2019.



Dr. Regina Renee Frost