

**UNITED STATES DISTRICT COURT
DISTRICT OF MARYLAND**

MAYOR AND CITY COUNCIL OF
BALTIMORE,

Plaintiff,

v.

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

Defendants.

Civil Action No.: 1:19-cv-01672-GLR

PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

Pursuant to Rule 56 of the Federal Rules of Civil Procedure, and this Court's July 2, 2019, July 31, 2019, and August 21, 2019 Marginal Orders, Plaintiff moves for summary judgment.

Included with this motion are Plaintiff's memorandum of law in support of the motion for summary judgment, which includes Plaintiff's opposition to Defendants' motion to dismiss or, in the alternative, for summary judgment, as well as Plaintiff's reply in support of its motion for a preliminary injunction. Also included are a declaration of Suzanne Sangree, exhibits containing excerpts of the administrative record, and a proposed order.

DATED: September 19, 2019

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CERTIFICATE OF SERVICE

I hereby certify that on September 19, 2019 the foregoing document was electronically filed with the Clerk of the Court using the CM/ECF system and all counsel of record will receive an electronic copy via the Court's CM/ECF system.

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Civil Action No.: 1:19-cv-01672-GLR

**PLAINTIFF'S (1) OPPOSITION TO DEFENDANTS' CONSOLIDATED
MEMORANDUM OF LAW IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS
OR, IN THE ALTERNATIVE, MOTION FOR SUMMARY JUDGMENT;
(2) MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFF'S MOTION FOR
SUMMARY JUDGMENT; AND (3) REPLY IN SUPPORT OF
PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION**

TABLE OF CONTENTS

INTRODUCTION1

ARGUMENT.....5

 I. The Rule violates the Administrative Procedure Act.5

 A. The Court Should Deny HHS’s Motion to Dismiss the APA
 Claims.6

 B. The Rule is Arbitrary and Capricious.7

 1. HHS’s justification for the changed policy is directly
 contrary to the Administrative Record.....8

 a. The Administrative Record refutes HHS’s
 justification for the Rule.8

 b. HHS failed to justify its reversal from the 2011
 Rule.11

 c. HHS failed to consider the reliance interests of
 healthcare providers.12

 2. HHS Refused to Consider Important Aspects of the
 Problem and Engaged in an Arbitrary Cost-Benefit
 Analysis.....13

 a. HHS failed to consider the Rule’s impact on
 patient health.13

 b. HHS Failed to Consider Impact on Providers.....16

 C. The Rule is not in accordance with federal law.17

 1. The Rule Conflicts with Sections 1554 and 1557 of the
 ACA17

 2. The Rule Conflicts with EMTALA20

 D. The Rule is in Excess of Statutory Authority22

 1. HHS Lacks Statutory Authority to Expand the Federal
 Conscience Statutes and Their Enforcement
 Mechanisms.22

a.	HHS lacks statutory authority to expand the substantive scope of the Federal Conscience Statutes.....	23
b.	HHS lacks statutory authority to give itself sweeping enforcement power over conscience violations.....	24
2.	The Rule’s Definitions Exceed and Conflict with Congressional Intent.	25
E.	The Rule is Unconstitutional.	30
1.	The City’s constitutional claims are ripe.	30
2.	The Rule violates the Establishment Clause.	35
a.	The Rule impermissibly favors religion by imposing costs and burdens of objecting employees’ religious beliefs on the City, its residents, and other third parties.	35
b.	The Rule impermissibly advances and endorses certain religious beliefs by accommodating those beliefs in the absence of substantial, government-imposed burdens on them.	39
c.	The Rule impermissibly coerces patients and healthcare providers to adhere to the government’s favored religious practices.	41
3.	The Rule violates the Spending Clause.	42
a.	The Rule is unconstitutionally coercive.....	42
b.	The Rule is unconstitutionally ambiguous.....	43
c.	The Rule imposes unconstitutionally retroactive conditions.....	45
d.	The conditions on funding are unrelated to conscience objections.....	47
II.	HHS’s Violations of the APA Require Holding the Rule Unlawful and Vacating and a National Injunction is Necessary to Preserve the Status Quo Until the Law Can be Set Aside.....	47
	CONCLUSION.....	50

TABLE OF AUTHORITIES

	Page(s)
Cases	
<i>Abbott Labs v. Gardner</i> , 387 U.S. 136 (1967).....	31
<i>Air All. Houston v. EPA</i> , 906 F.3d 1049 (D.C. Cir. 2018).....	23, 24, 25
<i>Am. Petroleum Inst. v. EPA</i> , 52 F.3d 1113 (D.C. Cir. 1995).....	22
<i>Arlington Cent. Sch. Dist. Bd. Of Educ. v. Murphy</i> , 548 U.S. 291 (2006).....	44
<i>Barghout v. Bureau of Kosher Meat & Food Control</i> , 66 F.3d 1337 (4th Cir. 1995)	41
<i>Barrick Goldstrike Mines, Inc. v. Browner</i> , 215 F.3d 45 (D.C. Cir. 2000).....	6
<i>Bowen v. Georgetown Univ. Hosp.</i> , 488 U.S. 204 (1988).....	22
<i>Burwell v. Hobby Lobby Stores, Inc.</i> , 573 U.S. 682 (2014).....	35, 36
<i>Cal. Indep. Sys. Operator Corp. v. FERC</i> , 372 F.3d 395 (D.C. Cir. 2004).....	22, 23
<i>California v. United States</i> , 2008 WL 744840 (N.D. Cal. Mar. 18, 2008).....	20, 33
<i>Casa de Maryland v. DHS</i> , 924 F.3d 684 (4th Cir. 2019)	5, 11, 12
<i>Chrisman v. Sisters of St. Joseph of Peace</i> , 506 F.2d 308 (9th Cir. 1974)	38
<i>City of Boerne v. Flores</i> , 521 U.S. 507 (1997).....	39

City of Portland, v. EPA,
507 F.3d 706 (D.C. Cir. 2007).....15

Clay v. United States,
537 U.S. 522 (2003).....25

Corporation of the Presiding Bishop of the Church of Latter-Day Saints v. Amos,
483 U.S. 327 (1987).....38, 39

Council of Parent Attorneys & Advocates, Inc. v. DeVos,
365 F. Supp. 3d 28 (D.D.C. 2019).....11

Cty. of Allegheny v. ACLU Greater Pittsburgh Chapter,
492 U.S. 573 (1989).....39

Cutter v. Wilkerson,
544 U.S. 709 (2005).....35, 36, 39

Dep’t of Commerce v. New York,
139 S. Ct. 2551 (2019).....2, 10

Doe v. Bolton,
410 U.S. 179 (1973).....38

Doe v. Phillips,
81 F.3d 1204 (2d Cir. 1996).....41

Dole v. Shenandoah Baptist Church,
899 F.2d 1389 (4th Cir. 1990)40, 47

Edwards v. Aguillard,
482 U.S. 578 (1987).....35

Encino Motorcars, LLC v. Navarro,
136 S. Ct. 2117 (2016).....7, 8

Ergon-W. Va., Inc. v. United States Envtl. Prot. Agency,
896 F.3d 600 (4th Cir. 2018)8

Estate of Thornton v. Caldor,
472 U.S. 703 (1985) (The Establishment Clause “gives no one the right to
insist that in pursuit of their own interests others must conform their conduct
to his own religious necessities.” (quoting *Otten v. Baltimore & Ohio R. Co.*,
205 F.2d 58, 61 (2d Cir. 1953) (Hand, J.))).....36, 37, 38

FCC v. Fox Television Stations, Inc.,
556 U.S. 502 (2009).....5, 8, 16

<i>Franklin v. Gwinnett Cty. Pub. Sch.</i> , 503 U.S. 60 (1992).....	45
<i>Freedom Holdings, Inc. v. Spitzer</i> , 408 F.3d 112 (2d Cir. 2005).....	49
<i>Gonzales v. Oregon</i> , 546 U.S. 243 (2006).....	22
<i>Goodall ex rel. Goodall v. Stafford Cty. Sch. Bd.</i> , 60 F.3d 168 (4th Cir. 1995)	40
<i>Healthy Teen Network v. Azar</i> , 322 F. Supp. 3d 647 (D. Md. 2018).....	46
<i>Henderson v. Kennedy</i> , 253 F.3d 12 (D.C. Cir. 2001).....	40
<i>Hernandez v. Comm’r</i> , 490 U.S. 680 (1989).....	40
<i>Hobbie v. Unemployment Appeals Comm’n</i> , 480 U.S. 136 (1987).....	39
<i>In re Microsoft Corp. Antitrust Litig.</i> , 333 F.3d 517 (4th Cir. 2003)	48
<i>Inouye v. Kemna</i> , 504 F.3d 705 (9th Cir. 2007)	41
<i>Islander E. Pipeline Co., LLC v. Connecticut Dep’t of Envtl. Prot.</i> , 482 F.3d 79 (2d Cir. 2006).....	9
<i>Kong v. Scully</i> , 341 F.3d 1132 (9th Cir. 2003)	38
<i>Larkin v. Grendel’s Den, Inc.</i> , 459 U.S. 116 (1982).....	41
<i>Larson v. Valente</i> , 465 U.S. 228 (1982).....	40
<i>Lee v. Weisman</i> , 505 U.S. 577 (1992).....	35, 41
<i>Lyng v. Nw. Indian Cemetery Protective Ass’n</i> , 485 U.S. 439 (1988).....	40

<i>Maryland v. King</i> , 133 S. Ct. 1 (2012).....	49
<i>McCreary Cty. v. ACLU of Ky.</i> , 545 U.S. 844 (2005).....	35
<i>MD/DC/DE Broadcasters Ass’n v. F.C.C.</i> , 236 F.3d 13 (D.C. Cir. 2001).....	48
<i>MedImmune, Inc. v. Genentech, Inc.</i> , 549 U.S. 118 (2007).....	31
<i>Mellen v. Bunting</i> , 327 F.3d 355 (4th Cir. 2003)	35, 41
<i>Miller v. Brown</i> , 462 F.3d 312 (4th Cir. 2006)	31, 33, 34
<i>Motion Picture Ass’n of Am. v. FCC</i> , 309 F.3d 796 (D.C. Cir. 2002).....	25
<i>Motor Vehicle Mfrs. Ass’n of U.S., Inc. v. State Farm Mut. Auto. Ins.</i> , 463 U.S. 29 (1983).....	<i>passim</i>
<i>Mountain Valley Pipeline, LLC v. W. Pocahontas Properties Ltd. P’ship</i> , 918 F.3d 353 (4th Cir. 2019)	48
<i>Nat’l Ass’n of Home Builders v. U.S. Army Corps of Engineers</i> , 417 F.3d 1272 (D.C. Cir. 2005).....	6
<i>Nat’l Cable & Telecomm. Ass’n v. Brand-X Internet Servs.</i> , 545 U.S. 967 (2005).....	26, 29
<i>Nat’l Family Planning & Reproductive Health Ass’n v. Gonzales</i> , 468 F.3d 826 (D.C. Cir. 2006).....	33
<i>Nat’l Fed’n of Indep. Bus. v. Sebelius</i> , 567 U.S. 519 (2012).....	42, 43, 45
<i>Nat’l Min. Ass’n v. U.S. Army Corps of Engineers</i> , 145 F.3d 1399 (D.C. Cir. 1998).....	49
<i>Nat’l Park Hosp. Ass’n v. Dep’t of Interior</i> , 538 U.S. 803 (2003).....	33
<i>New Jersey v. EPA</i> , 517 F.3d 574 (D.C. Cir. 2008).....	48

New York v. United States,
505 U.S. 144 (1992).....47

NRDC v. Rauch,
244 F. Supp. 3d 66 (D.D.C. 2017).....10

Ohio Forestry Ass’n v. Sierra Club,
523 U.S. 726 (1998).....31, 32

Organized Vill. of Kake v. U.S. Dep’t of Agric.,
795 F.3d 956 (9th Cir. 2015)11

Otten v. Baltimore & Ohio R. Co.,
205 F.2d 58 (2d Cir. 1953).....36

Pac. Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm’n,
461 U.S. 190 (1983).....32

Pennhurst State Sch. & Hosp. v. Halderman,
451 U.S. 1 (1981).....43

Perez v. Mortgage Bankers Ass’n,
135 S. Ct. 1199 (2015).....12

Pharm. Research & Mfrs. of Am. v. U.S. Dep’t of Health & Human Servs.,
43 F. Supp. 3d 28 (D.D.C. 2014).....22, 23, 25

Pub. Citizen v. Fed. Motor Carrier Safety Admin.,
374 F.3d 1209 (D.C. Cir. 2004).....15

Real Alternatives, Inc. v. Sec’y Dep’t of Health & Human Servs.,
867 F.3d 338 (3d Cir. 2017).....39

Regents of Univ. of Cal. v. U.S. Dep’t of Homeland Sec.,
908 F.3d 476 (9th Cir. 2018)47

Rosa H. v. San Elizario Indep. Sch. Dist.,
106 F.3d 648 (5th Cir. 1997)45

S.C. Coastal Conservation League v. Pruitt,
318 F. Supp. 3d 959 (D.S.C. 2018).....50

Samantar v. Yousuf,
560 U.S. 305 (2010).....28

Santa Fe Indep. Sch. Dist. v. Doe,
530 U.S. 290 (2000).....41

<i>Sensormatic Sec. Corp. v. Sensormatic Elecs. Corp.</i> , 452 F. Supp. 2d 621 (D. Md. 2006)	31
<i>Sherbert v. Verner</i> , 374 U.S. 398 (1963).....	36
<i>Smith v. Metro. Sch. Dist. Perry Twp.</i> , 128 F.3d 1014 (7th Cir. 1997)	44, 45
<i>South Dakota v. Dole</i> , 483 U.S. 203 (1987).....	42
<i>Stewart v. Azar</i> , 313 F. Supp. 3d 237 (D.D.C. 2018).....	13
<i>Sunrise Coop., Inc. v. United States Dep’t of Agric.</i> , 891 F.3d 652 (6th Cir. 2018)	18, 26
<i>Texas Monthly, Inc. v. Bullock</i> , 489 U.S. 1 (1989).....	35, 36, 38, 39
<i>Texas v. United States</i> , 201 F. Supp. 3d 810 (N.D. Tex. 2016)	34
<i>The Real Truth About Abortion, Inc. v. Fed. Election Comm’n</i> , 681 F.3d 544 (4th Cir. 2012)	50
<i>United States v. Lee</i> , 455 U.S. 252 (1982).....	36
<i>United States v. Mead Corp.</i> , 533 U.S. 218 (2001).....	26
<i>Util. Air Regulatory Grp. v. EPA</i> , 573 U.S. 302 (2014).....	25
<i>Virginia Soc’y for Human Life, Inc. v. Fed. Election Comm’n</i> , 263 F.3d 379 (4th Cir. 2001)	50
<i>W. Va. Dep’t of Health & Human Res. v. Sebelius</i> , 649 F.3d 217 (4th Cir. 2011)	45
<i>William v. Gonzales</i> , 499 F.3d 329 (4th Cir. 2007)	24, 28
Statutes	
5 U.S.C. § 704.....	31

5 U.S.C. § 706(2) *passim*

20 U.S.C. § 1682 24

26 U.S.C. § 5000A 1

29 U.S.C. § 794 (Rehabilitation Act of 1973) 24

42 U.S.C. § 238n 1, 27, 28

42 U.S.C. § 300a-7 1

42 U.S.C. § 1395dd(a), (b)(1), (c)(1) 20

42 U.S.C. § 2000d-1 24

42 U.S.C. § 6104 (Age Discrimination Act) 24

42 U.S.C. § 14406(1) 1

42 U.S.C. § 18023 1, 19

42 U.S.C. § 18081 1

42 U.S.C. § 18113 1, 24, 27

42 U.S.C. § 18114 3, 17, 18, 19

42 U.S.C. § 18116(a) 3, 17, 24

I.C.2 14

Appropriations Act 47

Consolidated Appropriations Act of 2009, Pub. L. No. 111-117, § 508(d)(1), 123
Stat. 3034 29

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

Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd 4, 17

EMTALA 14

Pub. L. 94-574, 90 Stat. 2721 31

Rules

Fed. R. Civ. P. 56(a)5
 Rule: (1) 1
 Rule 126

Regulations

45 C.F.R. § 88.4(a)(3), (5)32
 45 C.F.R. § 88.7(i)(3)(iv)–(v)42
 73 Fed. Reg. 78,08721
 76 Fed. Reg. 9968, 9973 (Feb. 23, 2011)11
 76 Fed. Reg. 996911, 12, 27
 76 Fed. Reg. 997047
 76 Fed. Reg. 9973-7412
 83 Fed. Reg. 23,170, 23,17247
 83 Fed. Reg. 3880 (Jan. 26, 2018)9, 10, 16
 83 Fed. Reg. 388610
 84 Fed. Reg. 23,170-01 (May 21, 2019)2
 84 Fed. Reg. 23,175-7611
 84 Fed. Reg. 23,17620
 84 Fed. Reg. 23,17934
 84 Fed. Reg. 23,18032, 44
 84. Fed. Reg. 23,18215
 84 Fed. Reg. 23,182-8321
 84 Fed. Reg. 23,1838, 21
 84 Fed. Reg. at 23,18314
 84 Fed. Reg. 23,19130

84 Fed. Reg. 23,192	29
84 Fed. Reg. 23,212	9
84 Fed. Reg. 23,220	24
84 Fed. Reg. 23,222	44
84 Fed. Reg. 23,229	10
84 Fed. Reg. 23,250	13
84. Fed. Reg. 23,252	15
84 Fed. Reg. 23,252-53	17
84 Fed. Reg. 23,254	10, 24
84 Fed. Reg. 23,263	<i>passim</i>
84 Fed. Reg. 23,263–23,265	37
84 Fed. Reg. 23,263–64 (to be codified at 45 C.F.R. § 88.2-88.3(a)-(c))	25
84 Fed. Reg. 23,264	28
84 Fed. Reg. 23,269	32
84 Fed. Reg. 23,272	43, 48
84 Fed. Reg. 23182-83	21
Constitutional Provisions	
U.S. Const., Article I, § 8, cl. 1	42
Other Authorities	
119 Cong. Rec. S9595 (Dec. 22, 1973)	27
151 Cong. Rec. H176-77 (Jan. 25, 2005)	20

INTRODUCTION¹

The Mayor and City Council of Baltimore (the City) is dedicated to improving and protecting the health of Baltimore’s uniquely vulnerable residents through delivery of stigma-free, trauma-informed, high-quality healthcare. The City administers health care through the Baltimore City Health Department (BCHD) and Emergency Medical Services (EMS) with over 50% federal funding, and in carrying out its public health mission, the City complies with the “Federal Conscience Statutes.”² Defendants do not contend otherwise, and nothing in the Administrative Record (AR) indicates that conscience protections have been generally misunderstood or under-enforced. Quite the contrary: The AR suggests that conscience protections are well-understood, rarely violated, and enforced when necessary.

The AR presents a far less rosy view of enforcement of the rights of *patients* against discrimination, based on who they are—for example, if the patients are lesbian, gay, bisexual, transgender, or queer (LGBTQ)—or the treatment they seek. While our nation’s history of protecting healthcare *recipients* against discrimination may not have its origins in “the beginning of this nation,” Mot. 1, federal law today protects patient rights to non-discriminatory health care through an equally robust set of statutory provisions, which HHS does not acknowledge until 30 pages into its brief, just as it failed to acknowledge those patient protections in promulgating the

¹ This brief serves as Plaintiff’s opposition to Defendants’ motion to dismiss or for summary judgment (“Mot.”) (Dkt. 44-1); Plaintiff’s cross-motion for summary judgment; and Plaintiff’s reply in support of its motion for preliminary injunction (“PI Motion”) (Dkt. 14-1).

² For ease of reference the City adopts HHS’s chosen term, “Federal Conscience Statutes,” to refer to the 4 main statutes HHS purports to enforce through the Rule: (1) the Church Amendments (42 U.S.C. § 300a-7); (2) the Coats-Snowe Amendment (42 U.S.C. § 238n(a)); (3) the Weldon Amendment (*see, e.g.*, Departments of Defense and Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2019, Div. B., sec. 507(d), Pub. L. No. 115-245, 132 Stat. 2981, 3118 (Sept. 28, 2018)); and (4) the conscience protection provisions in the Patient Protection and Affordable Care Act (ACA) (*i.e.*, 42 U.S.C. § 18113; 42 U.S.C. § 14406(1); 26 U.S.C. § 5000A; 42 U.S.C. § 18081; 42 U.S.C. § 18023(b)(1)(A) and (b)(4)). Mot. 4. The City does not address or include in this definition the statutes in footnote 1.

Rule entitled Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23,170-01 (May 21, 2019).

Under the guise of “clarifying,” the Rule vastly expands the scope of the Federal Conscience Statutes to allow anyone tangentially involved in the provision of healthcare to refuse, for “religious, moral, ethical, *or other reasons*,” to provide vital services and information to patients. 84 Fed. Reg. at 23,263. The Rule’s intended effect—to increase conscience-based refusals to provide care—will worsen health outcomes generally, and will especially, and irreparably harm the City’s most vulnerable populations, including women seeking reproductive care; LGBTQ individuals; minorities, and other underserved populations.

HHS has no authority to expand the federal laws that promote its current policy goals and flout the federal laws that do not serve its agenda. Yet this is exactly what HHS has done, without justification for its departure from longstanding federal policy, without any delegation from Congress, and without considering the concrete, harmful effects the Rule will have on patients and providers who have acted, for decades, in reliance on the Federal Conscience Statutes as written.

HHS attempts to insulate itself from review under the Administrative Procedure Act by calling its expansive Rule mere “housekeeping,” Mot. 20, and “clarifying,” *id.* at 39. HHS asks the Court to accept that it is the Federal Conscience Statutes themselves that elevate religious objections over other non-discrimination rights in health care. *Id.* at 44. That is wrong. The Rule is a drastic departure from those statutes’ plain language and legislative intent. This is unsurprising given that the expansion of religious rights was in furtherance of *executive* intent. President Trump acknowledged as much in announcing the Rule on May 2, 2019, proclaiming that it provided “*new*

protections of conscience rights.”³

The APA cabins agency authority and requires this Court to set aside the Rule in exactly the circumstances here:

(1) The Rule is arbitrary and capricious in several respects. HHS promulgated the Rule in a complete reversal of previous policy, without justification, and without considering the effect this reversal would have on the reliance interests of healthcare providers who have structured their organizations based on existing policy. The AR flatly refutes HHS’s stated rationale for the Rule—a purported “real and significant” increase in complaints for violation of conscience protections. HHS now admits the complaints on which it relied are largely “outside the scope of the Federal Conscience Statutes and the Rule.” Mot. 38. At the same time, HHS *ignored* voluminous evidence including hundreds of comments citing clear, specific examples of how expanding conscience protections would cause significant harm to the nation’s most vulnerable healthcare recipients, and impose impossible burdens on healthcare providers who seek to comply.

(2) The Rule is contrary to federal law. It seeks to expand conscience protections under the ACA, but violates both ACA Section 1554 (prohibiting enactment of regulations that create unreasonable barriers to, impede, interfere with, restrict, or violate healthcare access or informed consent) and ACA Section 1557 (prohibiting discrimination under any health program or activity on the basis of race, color, national origin, sex, disability, or age). 42 U.S.C. §§ 18114, 18116(a). In addition, the Rule acknowledges that its expanded definitions implicate emergency medical care, but recognizes no exception for emergencies, in violation of the prohibition on impairing

³ Summary Judgment Declaration of Suzanne Sangree (“Sangree Decl.”), Ex. 1 (Sanger-Katz, *Trump Administration Strengthens ‘Conscience Rule’ for Health Care Workers*, N.Y. Times, 2018, <https://www.nytimes.com/2019/05/02/upshot/conscience-rule-trump-religious-exemption-health-care.html> (last accessed Sept. 18, 2019)). All “Ex.” references are references to exhibits to the Sangree Decl.

access to emergency medical care under the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd.

(3) The Rule is in excess of statutory authority because HHS cites no authority to expand the definitions contained in the self-enforcing Weldon, Church, and Coats-Snowe Amendments, and HHS's definitions are contrary to the plain language and legislative intent of those statutes. HHS also cites no authority for the broad enforcement powers that it arrogates to itself and its Office for Civil Rights under the Rule.

(4) The Rule is unconstitutional. In violation of the Establishment Clause of the First Amendment, it elevates the beliefs of objecting employees above the rights and beliefs of providers and patients and at great cost to the City's overall public health. And it coerces the City, providers, and patients to adhere to the government's favored religious practices. It exceeds Congress's Spending Clause authority by threatening millions of dollars of federal funding, putting the City at risk of ruinous sanctions.

It is telling that HHS's motion *for summary judgment* contains but four references to the over-500,000-page AR. Instead of offering evidentiary support for its expansion of the Federal Conscience Statutes, HHS attempts to insulate its expansive Rule from review by stating that it is merely "clarifying" existing law, and by promising that provisions of the Rule apply only "to the extent permitted by the applicable statute." Mot. 25-26, 30. This refrain cannot change the plain effect of the Rule which *does* "change ... the substantive requirements of the Federal Conscience Statutes," Mot. 2, and simultaneously gives HHS unbridled discretion to decide what the Federal Conscience Statutes permit. It is no limitation at all.

HHS also tries to dismiss the City's well-supported assertion of harm as a "parade of horrors" too speculative to warrant relief. Mot. 53. But unlike HHS's claim of underenforcement

of the Federal Conscience Statutes, the Rule's harms are supported by extensive evidence in the AR (which HHS impermissibly ignored), sworn declarations filed with the City's PI Motion, and acknowledgments in the Rule itself that it will increase denials of care without regard to the harms to patients and providers, and that HHS will rigorously protect such denials.

For all these reasons, explained in detail below, the Court should grant summary judgment for the City and set aside the Rule before its effective date of November 22, 2019. Or if the Court is unable to decide the merits before that date, it should issue a nationwide preliminary injunction to prevent irreparable harm to the City, its public health, and the City's insureds, who reside in every state and will therefore be at grave risk of harm if the Rule is implemented anywhere.

Relevant factual and procedural background regarding the City's healthcare system, the statutory framework governing non-discrimination in healthcare and the requirement of uninterrupted care, and the history of the Rule are found at PI Motion 3-11.

ARGUMENT

I. The Rule violates the Administrative Procedure Act.

The City is entitled to summary judgment because "there is no genuine dispute as to any material fact" and, as a matter of law, the Rule violates the APA. Fed. R. Civ. P. 56(a). Under the APA, courts must "hold unlawful and set aside" agency action that is "in excess of statutory jurisdiction, authority, or limitations"; that is "not in accordance with law"; that is "arbitrary, capricious, [or] an abuse of discretion"; or that is "contrary to constitutional right, power, privilege, or immunity." 5 U.S.C. §§ 706(2)(A)-(C). A finding in the affirmative on any of these grounds warrants summary judgment in favor of the City. The Court "must engage in a searching and careful inquiry of the [administrative] record, so that [it] may consider whether the agency considered the relevant factors and whether a clear error of judgment was made." *Casa de Maryland v. DHS*, 924 F.3d 684, 703 (4th Cir. 2019); *see also FCC v. Fox Television Stations*,

Inc., 556 U.S. 502, 537 (2009) (Kennedy, J., concurring) (purpose of the APA is to “confine[] agencies’ discretion and subject[] their decisions to judicial review.”).

A. The Court Should Deny HHS’s Motion to Dismiss the APA Claims.

Though HHS moves to dismiss all claims under Rule 12(b)(1) and 12(b)(6), Mot. 15, it makes no specific Rule 12 argument regarding the non-constitutional APA claims and there is no basis to dismiss under Rule 12.

HHS’s Rule 12 argument, if predicated on there being some bar to “facial challenges to the Rule,” Mot. 15, is incorrect. HHS erroneously relies on cases recognizing that facial constitutional challenges to *statutes* are more difficult than as-applied ones. *Id.* By contrast, courts regularly hold that facial APA challenges that an agency “exceeded its statutory authority” or “failed to offer a reasoned basis for [a rule’s] conditions and restrictions” are “legal challenges [are] subject to review.” *Nat’l Ass’n of Home Builders v. U.S. Army Corps of Engineers*, 417 F.3d 1272, 1281 (D.C. Cir. 2005). Indeed, “a purely legal claim in the context of a facial challenge, such as the [City’s] claim, is presumptively reviewable.” *Id.* (internal quotation marks and citation omitted); *see also Mountain States Tel. & Tel. Co.*, 939 F.2d at 1041 (“In light of the wholly legal and facial nature of the present challenge, we cannot agree that our ability to review the agency’s decision would be increased by delay.”). Courts routinely reject contentions, like HHS’s here (Mot. 2), that predictions about the potential loss of funding are not ripe. As a matter of law, an action challenging a rule is ripe when the plaintiff’s “only alternative to obtaining judicial review now is to violate [the rule’s] directives . . . and then defend an enforcement proceeding on the grounds” that might have been raised in a pre-enforcement challenge. *Barrick Goldstrike Mines, Inc. v. Browner*, 215 F.3d 45, 49 (D.C. Cir. 2000). As set forth in detail in the City’s PI Motion, requiring the City to test the Rule would result in irreparable harm. PI Motion 36-46. The Court should deny HHS’s motion to dismiss.

B. The Rule is Arbitrary and Capricious.

As set forth in Sections I.C-I.E, *infra*, the Rule expands the Federal Conscience Statutes well beyond any delegated statutory authority and directly contravenes federal statutes and constitutional mandates. But the Court need not reach those issues because HHS failed to comply with “basic procedural requirements,” and the Rule is therefore “arbitrary and capricious and so cannot carry the force of law.” *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125 (2016); 5 U.S.C. § 706(2)(A).

The Rule fails under each test for arbitrary and capricious rulemaking: HHS (1) “relied on factors which Congress has not intended it to consider,” (2) “entirely failed to consider an important aspect of the problem,” and (3) “offered an explanation for its decision that runs counter to the evidence before the agency ... [and] could not be ascribed to a difference in view or the product of agency expertise.” *Motor Vehicle Mfrs. Ass’n of U.S., Inc. v. State Farm Mut. Auto. Ins.*, 463 U.S. 29, 43 (1983). In addition, where “as here, an agency adopts a rule that directly contradicts prior agency conclusions of fact and law, it must acknowledge that it is doing so and give a reasonable justification for the change.” *Encino Motorcars*, 136 S. Ct. at 2126.

The Rule elevates conscience objections over the rights of patients based on the assertion that such conscience objections are inadequately protected—an assertion that is unsupported by, and contrary to, the AR, as evidenced by HHS’s failure to cite more than three complaints, only one of which alleged an actionable violation under a Federal Conscience Statute. In contrast, HHS failed to consider, and expressly ignored, the extensive, non-speculative evidence in the AR that the Rule will harm patient health, and impede the ability of healthcare providers like the City to comply with its legal mandate and public health mission to provide uninterrupted non-

discriminatory healthcare. On each of these grounds, and as a whole, the Rule is arbitrary and capricious and cannot stand.

1. HHS’s justification for the changed policy is directly contrary to the Administrative Record.

HHS admits that the Rule “undeniably revises HHS’s approach to enforcing the Federal Conscience Statutes” and, thus, the agency must show that “the new policy is permissible under the statute [and] that there are good reasons for it.” Mot. 37 (quoting *Fox Television*, 556 U.S. at 515); *Encino Motorcars*, 136 S. Ct. at 2126. HHS’s failure to “give adequate reasons for its decisions,” to “examine the relevant data,” or to draw a “rational connection between the facts found and the choice made” requires setting aside the Rule. *Id.* at 2125.

a. The Administrative Record refutes HHS’s justification for the Rule.

The AR shows that HHS “explain[ed] its decision in a manner contrary to the evidence before it,” rendering the Rule arbitrary and capricious. *Ergon-W. Va., Inc. v. United States Env’tl. Prot. Agency*, 896 F.3d 600, 613 (4th Cir. 2018). HHS asserts conclusorily that its change in policy was “well-grounded in the evidence before the agency” that “the preexisting regulatory structure was insufficient to protect the statutory rights and liberty interests of health care entities,” and that the “2011 Rule lacked adequate measures to ensure compliance.” Mot. 38. HHS’s failure to point to *any* evidence in the AR in support of this claim, and an independent review of the AR, confirm that this rationale is baseless: the Rule is a solution in search of a problem.

HHS contends that OCR received 34 complaints regarding conscience protections between November 2016 and January 2018, and 343 complaints during fiscal year 2018. 84 Fed. Reg. at 23,183 (asserting 343 complaints as justifying Rule); *id.* at 23,245 (asserting 343 complaints as justifying reporting costs); *id.* (asserting 343 complaints as justifying enforcement costs). But HHS cites only its own statements in the Preamble and Notice of Proposed Rulemaking—and nothing

in the AR—to support its contention that “[t]he increase in complaints was both real and significant.” Mot. 38 (citing Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880 (Jan. 26, 2018) (“NPRM”). And HHS *admits* that “a large subset of [the 343 complaints] complain of conduct that is outside the scope of the Federal Conscience Statutes and the Rule” and hence are irrelevant here. *Id.* Even this admission vastly overstates support in the AR for HHS’s policy reversal.

HHS cites a grand total of *three* complaints in the AR that it says justify the Rule.⁴ This is a far cry from the 343 complaints in fiscal year 2018 touted repeatedly in the Rule. A court may not “construct support for an agency’s conclusion when the agency has not pointed to evidence on the record favoring its decision.” *Islander E. Pipeline Co., LLC v. Connecticut Dep’t of Envtl. Prot.*, 482 F.3d 79, 101–02 (2d Cir. 2006) (invalidating agency rule as arbitrary and capricious) (citing *State Farm*, 463 U.S. at 50).

Of the supposed 343 complaints, almost 80% relate to vaccinations, which Defendants concede are beyond the scope of the Rule. *See* 84 Fed. Reg. at 23,183, 23,212; Mot. 38 & n.5 (citing a single vaccination complaint as an example of conduct “outside the scope” of the Rule). *See* Ex. 2 (listing vaccination complaints). Numerous other complaints in the AR have nothing to

⁴ Only one of the three complaints—selected by Defendants as the only record evidence in their motion for summary judgment—even alleges a violation under the Federal Conscience Statutes. Mot. Ex. C (AR544613) (Dkt. 44-4). One is from an employee of the Washington State Department of Corrections, alleging discrimination based on a refusal to provide hormone therapy to incarcerated transgender persons and does not implicate and HHS-funded program. *See* Mot. Ex. A (AR54188) (Dkt. 44-2). To the extent HHS views such refusals as subject to the Rule, that simply confirms the City’s concern about the deleterious effects of the Rule on transgender individuals. And one, Mot. Ex. B (AR544516) (Dkt. 44-3), complains of competing lobbying efforts between competing organizations of doctors. It does not identify a single instance of discrimination by any entity, and certainly not an entity covered by the Federal Conscience Statutes.

do with the Federal Conscience Statutes.⁵ Some even *oppose* expansion of conscience protections.⁶ Finally, the AR reveals that, where HHS did investigate genuine complaints, they were *satisfactorily resolved* under the existing 2011 Rule,⁷ as HHS conceded in the NPRM. *See* 83 Fed. Reg. at 3886 (explaining that OCR conducted investigations of complaints and, in response, entities revised policies, posted notices, and trained personnel about statutory obligations). The AR thus confirms that existing enforcement is more than adequate.

In short, HHS’s central claim that it received 343 complaints in fiscal year 2018 alleging violations of conscience laws turns out to be false and renders the Rule invalid.⁸ *See Dep’t of Commerce v. New York*, 139 S. Ct. 2551, 2575 (2019) (invalidating agency action where “the evidence tells a story that does not match the explanation the Secretary gave for his decision”); *NRDC v. Rauch*, 244 F. Supp. 3d 66, 96 (D.D.C. 2017) (citing *State Farm*, 463 U.S. at 43) (“[I]t is arbitrary and capricious for an agency to base its decision on a factual premise that the record

⁵ *See e.g.*, Ex. 3, AR 542627-36 (complaint filed because federal agencies forced complainant to remove social media ads for “divine cure for cancer”); Ex. 4, AR 543082-90 (parent alleging discrimination against a health care entity because parent did not want newborn to have a newborn screening test); Ex. 5, AR 543879-82 (allegations of identity theft and health care fraud); Ex. 6, AR 544035-43 (complainant upset about needing to purchase coverage for unneeded prescriptions); Ex. 7, AR 544235-43 (allegations of HIPAA violations when an entity posted medical records online); Ex. 8, AR 544753-62 (employee complains of suspension for refusing to meet with board of directors regarding unspecified grievances).

⁶ *See* Ex. 9, AR 542414-22 (stating that HHS’s actions are “an appalling, unethical abuse of ‘religious freedom’ to impose archaic religious ideals on citizens in order to deny them civil liberties and health care”); Ex. 10, AR 542449 (“The Current Administration has allowed religious Zealots to run health information agencies.”).

⁷ *See, e.g.*, Ex. 11, AR 541967 (OCR closed matter because complaint failed to state a claim of discrimination); Ex. 12, AR 541805 (complaint withdrawn when grantee took actions to come into compliance).

⁸ HHS now attempts to downplay its reliance on the complaints, claiming that they were only “one of the many metrics used to demonstrate the importance of this rule.” Mot. 38 (citing 84 Fed. Reg. at 23,229). However, HHS cites no other metrics, or even anecdotal evidence, to support its conclusion that “the status quo was not adequately protecting at least some health care providers who object to participating in certain care.” Mot. 43 (citing 84 Fed. Reg. at 23,254).

plainly showed to be wrong.”). HHS cites to nothing in the AR “to explain why the [existing] safeguards as a whole would not prevent against the risk” purportedly addressed and thus the Rule cannot stand. *Council of Parent Attorneys & Advocates, Inc. v. DeVos*, 365 F. Supp. 3d 28, 50 (D.D.C. 2019).

b. HHS failed to justify its reversal from the 2011 Rule.

The Rule is also arbitrary and capricious because HHS “had before it . . . a reasoned analysis” and “changed course without any explanation for why that analysis was faulty.” *Casa de Maryland*, 924 F.3d at 705. Here, HHS relies on the same evidence it considered in promulgating the 2011 Rule (76 Fed. Reg. 9968, 9973 (Feb. 23, 2011)), which rescinded parts of the 2008 Rule including many of the same expansive provisions in the challenged Rule. *See, e.g.*, 84 Fed. Reg. at 23,175-76 (citing a 2009 survey, a 2009 journal article, a 2010 news report, and comments in response to the proposed rescission of the 2008 Rule). In 2011, after considering this record evidence, HHS found that (1) “the 2008 final rule attempting to clarify the Federal health care provider conscience statutes ha[d] instead led to greater confusion,” 76 Fed. Reg. at 9969; (2) “the 2008 Final Rule may negatively affect the ability of patients to access care if interpreted broadly,” *id.* at 9974; and (3) the certification requirements imposed by the 2008 Rule “created unnecessary additional financial and administrative burdens on health care entities,” *id.*

HHS’s reliance on the same, now-ten-years-old evidence to reach the opposite conclusions—with no explanation of why its assessment of those facts in 2011 was incorrect—is arbitrary and capricious. *See Casa de Maryland*, 924 F.3d at 705; *Organized Vill. of Kake v. U.S. Dep’t of Agric.*, 795 F.3d 956, 968 (9th Cir. 2015) (en banc) (finding agency’s decision arbitrary and capricious when “it made factual findings directly contrary to” previous policy following change in presidential administrations and “expressly relied on those findings to justify the policy change”).

c. HHS failed to consider the reliance interests of healthcare providers.

In addition, the Rule is arbitrary and capricious because HHS failed to account for the fact that “its prior policy has engendered serious reliance interests.” *Perez v. Mortgage Bankers Ass’n*, 135 S. Ct. 1199, 1209 (2015) (internal quotation marks omitted). The 2011 Rule recognized that federal law, including the Federal Conscience Statutes, “strike a careful balance between the rights of patients to access needed health care, and the conscience rights of health care providers” and that “[t]hey were never intended to allow providers to refuse to provide medical care to an individual because the individual engaged in behavior the health care provider found objectionable.”⁹ 76 Fed. Reg. at 9973-74. In promulgating the Rule, HHS ignored extensive record evidence (and fails in its motion to address that evidence) that healthcare providers, like the BCHD clinics and EMS, arranged their affairs in reliance on existing enforcement of the Federal Conscience Statutes and the 2011 Rule’s recognition of the need to protect access to health care.

10

HHS’s complete failure to consider how providers “structured their [practices]” in reliance on the existing enforcement framework was arbitrary and capricious and requires setting aside the Rule. *Casa de Maryland*, 924 F.3d at 705.

⁹ Defendants’ assertion that HHS rescinded the 2008 Rule because of “concerns about whether the Rule was consistent with the new administration’s priorities,” Mot. at 10-11, lacks any support—and is a transparent projection of Defendants’ own sins onto others. The 2011 Rule partially rescinded expansions of the statutes in the 2008 Rule that were “unclear and potentially overbroad in scope” based on consideration of comments in the administrative record. 76 Fed. Reg. at 9969.

¹⁰ See, e.g., Ex. 13, AR 67173 (Wash. Dep’t of Health); Ex. 14, AR 71138 (Ass’n of Am. Med. Colls.); Ex. 15, AR 137905 (Calif. Dep’t of Justice); Ex. 16, AR 137920 (Attorneys General Including Maryland); Ex. 17, AR 138102 (Nat’l Family and Reproductive Health Assoc); Ex. 18, AR 140265 (BlueCross BlueShield Ass’n); Ex. 19, AR 140350 (Calif. Dep’t of Insurance); Ex. 20, AR 140484 (NYC Commission on Human Rights); Ex. 21, AR 147746 (ACLU); Ex. 22, AR 147824 (Greater New York Hospital Ass’n); Ex. 23, AR 160751 (Planned Parenthood).

2. HHS Refused to Consider Important Aspects of the Problem and Engaged in an Arbitrary Cost-Benefit Analysis.

In defense of its cost-benefit analysis HHS relies on a single 2009 poll (relied on in the 2011 Rule to reach the opposite conclusion) for the conclusion that the Rule would increase the number of health care providers, improve the doctor-patient relationship, eliminate harm from requiring health care entities to violate their consciences, and reduce unlawful discrimination in the workplace. Mot. 40. HHS does not reference the AR.¹¹ While HHS is free to consider these potential benefits, it is not free to completely disregard other important aspects of the problem, such as patient health, which HHS effectively admits it did. Mot. 42 (“HHS received no data that would “enable[] a reliable quantification of the effect of the [R]ule on access to providers and to care,” 84 Fed. Reg. 23,250). HHS’s motion confirms that its assessment of the effects of the Rule was arbitrary and capricious.

a. HHS failed to consider the Rule’s impact on patient health.

The Rule must be set aside because HHS “entirely failed to consider an important aspect of the problem”—the impact on patient access to health care. *State Farm*, 463 U.S. at 43; *see also Stewart v. Azar*, 313 F. Supp. 3d 237, 263 (D.D.C. 2018) (vacating HHS secretary action where the Court had “little reason to think that he seriously grappled with the bottom-line impact on healthcare”).

In contrast to the negligible evidence in the AR that conscience protections are too *narrowly* construed or inadequately enforced, the record is replete with concrete evidence that the Rule will harm patients, especially LGBTQ patients, reproductive-healthcare patients, and economically disadvantaged patients. Contrary to HHS’s assertion that it “received no data that

¹¹ HHS claims it relied on “comments” and “anecdotal evidence” but it supplies none in support of its motion for summary judgment. Mot. 40.

would ‘enable a reliable quantification of the effect of the rule on access to providers and to care,’” Mot. 41, HHS improperly disregarded substantial evidence in the AR that the Rule will negatively affect patient access to care and patient health outcomes by:

(1) Increasing the number of asserted religious objections to a wider variety of care, including reproductive care, care for transgender patients, counseling for same-sex partners, and HIV/AIDS treatment, thus erecting additional barriers to already marginalized groups with a disproportionate effect on economically disadvantaged patients, who make up the vast majority of the City’s healthcare recipients;¹² and (2) creating, through the absence of any exception for emergencies, a real risk that patients will be denied care in emergency situations, in contravention of EMTALA (*see* Section I.C.2, *infra*). *See* 84 Fed. Reg. at 23,183 (in response to comment about EMTALA, responding simply that “The Department intends to give all laws their fullest *possible* effect.”) (emphasis added); *id.* at 23,188 (“declin[ing] to take ... a categorical approach” to when an ambulance crew would qualify as “assisting in the performance” and noting that “EMTALA might apply in a particular case”).¹³

¹² *See, e.g.*, Ex. 24 AR140667 (Mazzoni Center Comment) (rule will exacerbate discrimination against LGBTQ and individuals with HIV); Ex. 25, AR137857 (LGBTQ and women of color); Ex. 26 AR139354 (LGBTQ); Ex. 27, AR139547 (women, LGBTQ); Ex. 28 85 at 140153; Ex. 29, AR139287 (LGBTQ); Ex. 30, AR140507 (LGBTQ); Ex. 31, AR135450 (LGBTQ, HIV); Ex. 32, AR66545 (LGBTQ, women, people of color, low-income); Ex. 33, AR55806 (LGBTQ); Ex. 34, AR135824 (LGBTQ and HIV); Ex. 35, AR140153 (LGBTQ); Ex. 36, AR160566 (LGBT); Ex. 37, AR160801 (LGBTQ and marginalized women); Ex. 38 AR66037 (gender affirming surgery, reproductive healthcare); Ex. 39, AR161316 (LGBTQ, economically-disadvantaged).

¹³ *See, e.g.*, Ex. 40, AR137574 (New York Civil Liberties Union comment that rule puts patients at risk by ignoring EMTALA) Ex. 41, AR139587 (Am. Med. Assoc.); Ex. 33, AR55806 (Santa Clara County); Ex. 37, AR160801 (Ctr. for Reproductive Rights); Ex.32, AR66545 (Raising Women’s Voices); Ex. 29, AR139287 (Boston Med. Ctr.); Ex. 42; Ex. 43 AR57519 (Nat’l Inst. Reproductive Health); Ex. 44, AR147890 (Anne Arundel Center); Ex. 45, AR161033 (Medicare Rights Center); Ex. 46, AR55622 (Oregon Foundation for Reproductive Health); Ex. 47, AR139925 (Colorado Consumer Health Initiative).

HHS's stated reasons for ignoring this evidence are legally insufficient. HHS contends that "[n]o comment attempted a detailed description of the actual impact expected from the rule on access to care, health outcomes, and associated concerns." 84. Fed. Reg. at 23,252. Wrong. The AR contains hundreds of lengthy comments, including but not limited to the examples attached to this motion, citing in detail real-world examples of the "actual impact expected ... on access to care [and] health outcomes." Indeed, *HHS's own statements* in the Rule recognize that denials under the Rule may result in all "[d]ifferent types of harm" including to harm to "the patient's health," "distress" and a patient being "less willing to seek medical care." *Id.* at 23,251. But HHS must *respond* to "significant comments" in a rulemaking proceeding—those "which, if true, raise points relevant to the agency's decision" and, if adopted, would require a change in the agency rule. *City of Portland, v. EPA*, 507 F.3d 706, 715 (D.C. Cir. 2007) (quotation omitted, emphasis in original). The assertion that the "effect[] [of a rule] is *uncertain* is no justification for *disregarding* the effect entirely." *Pub. Citizen v. Fed. Motor Carrier Safety Admin.*, 374 F.3d 1209, 1219 (D.C. Cir. 2004) (emphases in original) (holding that assumption that "effects are nil is implausible"). HHS was not free to dismiss these concrete harms as it did.

HHS nevertheless finalized the Rule "*without regard* to whether data exists on the competing contentions about its effect on access to services" because, it contends, *Congress* deemed religious refusals "worth protecting even if they impact overall or individual access to a particular service, such as abortion." 84. Fed. Reg. at 23,182. That is a statement of the *agency's* revised priorities, *not* Congress's. As set forth in Sections I.C and I.D, *infra*, Congress's expressed intent and the legislative framework of the Federal Conscience Statutes show the opposite intent—to ensure that conscience protections and patients' right to non-discriminatory health care exist in harmony. The Rule's elevation of conscience over the right to healthcare is a product of *HHS's*

revised priorities. The Court should reject the agency's repeated attempts to conflate its agenda with that of Congress.

HHS is not free to dismiss hundreds of AR comments citing real-world examples of adverse health impacts and other concrete evidence as "anecdotal,"¹⁴ Mot. 42, in favor of non-existent evidence (i.e., a purported 343 complaints of conscience violations). That is arbitrary and capricious. Because Defendants utterly "failed to consider [these] important aspect[s]" of the rulemaking, the Rule must be set aside. *State Farm*, 463 U.S. at 43.

b. HHS Failed to Consider Impact on Providers

Likewise, HHS's conclusory assertion that the Rule will increase the number of providers, Mot. 41, ignores numerous comments from major medical associations, provider groups, academics, and experts who raised concerns that the Rule will be impracticable and exceedingly costly.¹⁵

¹⁴ HHS argues that the comments regarding how *expanded* conscience protections will increase discrimination "[d]o not attempt to answer the question of how the Rule itself would affect access to health care." Mot. 42. But if, as numerous studies show, religious objections are linked with discrimination, it follows that discrimination will increase with expansion of conscience protections. The causal relationship between widespread discrimination and the Rule is a simple "exercise in logic." *Fox Television*, 556 U.S. at 521.

¹⁵ *See, e.g.* Ex. 29, AR139287 (Boston Medical Center comment that the NPRM's predicted expenditures for enforcement conflict with the "calls to action and efforts being made to bring down the costs of health care throughout the United States."); Ex. 48, AR151666 (Calif. Med. Assoc. comment that the NPRM failed to consider "the significant time and resources it takes to continuously implement and enforce" the Rule and that these proposed "[e]xcessive administrative tasks" "divert time and focus from providing actual care to patients."; *see also* Ex. 49, AR67413 (American Hospital Association explaining that the Rule is "burdensome" and "unnecessary" and "create[s] a presumption of noncompliance"); Ex. 41, AR139587 (AMA stating that "it remains unclear why OCR would require physicians to make two separate attestations of compliance to the same requirements, particularly given the administration's emphasis on reducing administrative burden").

Ignoring this evidence, HHS contends it was justified in relying on the “limited” data i¹⁶ to conclude that the Rule will “increase, or at least not decrease” available providers. Mot. 40-41. But HHS does not cite to *any data* in the AR, reliable or otherwise, for this conclusory assertion. The most concrete evidence shows the opposite: after HHS rescinded the 2008 Rule in 2011, the predicted exodus of religious healthcare providers never materialized. HHS does not point to a single example of a provider who stopped practicing medicine as a result of the 2011 Rule.

Each of these procedural deficiencies is individually sufficient to warrant setting aside the Rule as arbitrary and capricious. Together they show that the Rule is deficient and cannot carry the force of law.

C. The Rule is not in accordance with federal law.

The APA provides that the Court shall “hold unlawful and set aside” agency action that is “not in accordance with law.” 5 U.S.C. § 706(2)(A). As set forth in the City’s PI Motion at 10, 17-20 and below, the Rule: (1) violates the ACA’s Non-Interference Mandate (Section 1554), 42 U.S.C. § 18114, and its Non-Discrimination Mandate (Section 1557), *id.* § 18116; and (2) violates Congress’s prohibition on impairing access to emergency medical care under EMTALA, 42 U.S.C. § 1395dd. Each violation independently warrants setting the Rule aside under 5 U.S.C. § 706(2)(A).

1. The Rule Conflicts with Sections 1554 and 1557 of the ACA

HHS admits (Mot. 22) that the ACA is the *only* Federal Conscience Statute that delegates authority to HHS—and then only in the limited contexts set forth in the statute. Defendants seize

¹⁶ HHS relied on “a limited 2009 poll” to conclude that the Rule would increase the number of health care providers. Mot. 40 (citing 84 Fed. Reg. at 23,247). The poll in question, aside from its highly dubious methodology, was conducted in an entirely different regulatory context. The poll surveyed “faith-based health care professionals” when the 2008 Rule was in effect about what they predicted would occur if that Rule were rescinded. 84 Fed. Reg. at 23,252-53. HHS cites no other evidence.

upon this limited authority to promulgate regulations under numerous *other* statutes that provide no such express or implicit authority to HHS. *Id.* At the same time, Defendants seek to ignore the clear and unambiguous restrictions Congress imposed on HHS's regulatory authority under the ACA. HHS is not free to expand its authority under the ACA, nor is it free to ignore restrictions on that limited authority. Certainly, HHS cannot have it both ways.

Section 1554's Non-Interference Mandate. Congress's directive to HHS is clear and unambiguous: "Notwithstanding any other provision of this Act," HHS "shall not promulgate any regulation that" (1) "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care;" (2) "impedes timely access to health care services;" or (3) "interferes with communications regarding a full range of treatment options between the patient and provider." 42 U.S.C. § 18114. Congress unambiguously restricted HHS's authority to encroach upon patient rights to health care. HHS cannot "under the guise of interpretation" expand conscience protections in a manner "foreclosed by the statute." *Sunrise Coop*, 891 F.3d at 654 (setting aside agency action that "under the guise of interpretation, nevertheless imposed additional eligibility requirements . . . unmoored from the statute."). The Rule "creates unreasonable barriers" to, "impedes timely access" to, and "interferes with communications" regarding healthcare for the City's most vulnerable populations—women, LGBTQ individuals, people with disabilities, and other historically marginalized groups. *See* PI Motion 5-8, 36-46; Declaration of Rebecca Dineen ¶¶ 81-90 (Dkt. 14-2) (Dineen Decl.) (describing barriers to access for economically disadvantaged women and children); Declaration of Letitia Dzirasa ¶¶24-28 (Dkt. 14-3) (Dzirasa Decl.) ("Denials of service will cause patients to delay seeking medical care...driving away existing patients and deterring high-risk individuals from seeking care."); Declaration of Adena Greenbaum ¶¶ 79-86 (Dkt. 14-6) (Greenbaum Decl.) (describing barriers to

access to patients with HIV and LGBTQ patients). “[U]nder the guise of interpretation” the Rule contravenes Congress’s “clear” directive under Section 1554 and must be set aside.

HHS again attempts to insulate its vastly expanded Rule—this time from Congress’ Non-Interference Mandate *and* from APA review—by equating the Rule with the Federal Conscience Statutes themselves and arguing that the City reads Section 1554 to “abrogate[]” those *statutes*. Mot. 42. But Section 1554 says *nothing* about the Federal Conscience Statutes or statutes generally—it speaks only to *HHS’s* authority to issue *regulations*. Section 1554’s Non-Interference Mandate limits HHS’s *rulemaking* discretion to elevate conscience protections in a manner that impedes patient access to health care—exactly what the Rule does.

HHS has two responses, neither of which is persuasive. *First*, HHS argues (without citation to any law) that because Section 1554 says “Notwithstanding any other provision *of this Act*” it only governs the ACA. As an initial matter, the Non-Interference Mandate is not restricted to regulations under the ACA—it states clearly that HHS “shall not promulgate *any* regulation.” 42 U.S.C. § 18114 (emphasis added). In any event, HHS’s authority under the ACA is the *only* authority HHS identified to implement the Rule. Mot. 32. HHS cannot interpret the ACA to authorize it to interpret and enforce *all conscience statutes*—the ACA does not grant this authority, *see* Section I.D, *infra*—and then argue that the ACA’s restriction of rulemaking authority does not extend to HHS’s expansion of its authority.

Second, HHS attempts to nullify Section 1554 by arguing that ACA Section 1303(c)(2) states that the ACA shall not affect other “*Federal laws*” regarding conscience protection, and therefore that HHS’s (unauthorized) *regulations* interpreting those laws are immune from Section 1554. Mot. 32 (quoting 42 U.S.C. § 18023(c)(2)). Regulations are not laws. The Rule is subject to, and irreconcilable with, ACA Section 1554.

Section 1557’s Non-Discrimination Mandate. ACA Section 1557 prohibits discrimination under any health program or activity on the basis of race, color, national origin, sex, disability, or age. The Rule violates that antidiscrimination mandate because it permits providers, insurers, plan sponsors (i.e., employers), and other healthcare personnel and entities to exempt themselves from providing a broad range of benefits and services—including contraceptives (84 Fed. Reg. at 23,176), emergency miscarriage management (*id.* at n.27), tubal ligations and hysterectomies (*id.*), and treatment for gender dysphoria (*id.*)—to women and to the LGBTQ community. HHS does not dispute that the Rule by its terms authorizes violations of Section 1557. Instead, it offers the empty promise that, in enforcing the Rule, it intends “to read every law passed by Congress in harmony to the fullest extent possible,” including Section 1557. Mot. 34. HHS cannot insulate a Rule that authorizes violations of Section 1557 by promising that when it is “rigorously” enforcing the unlawful Rule, it won’t do so unlawfully.

2. The Rule Conflicts with EMTALA

EMTALA requires hospitals participating in the federal Medicare and Medicaid programs with emergency rooms to screen patients to determine “whether or not an emergency medical condition . . . exists” and, if so, to stabilize the patient or transfer her to another facility. 42 U.S.C. § 1395dd(a), (b)(1), (c)(1). There is no evidence that Congress intended the Federal Conscience Statutes to override EMTALA. Congress intended just the opposite. *See* 151 Cong. Rec. H176-77 (Jan. 25, 2005) (statements by Rep. Weldon acknowledging EMTALA and noting that the Weldon Amendment prohibits coercion only in “nonlife-threatening situations,” whereas when the “mother’s life is in danger a healthcare provider must act to protect the mother’s life”); *California v. United States*, 2008 WL 744840, at *4 (N.D. Cal. Mar. 18, 2008) (no indication “from the express language of [Weldon] . . . that enforcing . . . EMTALA to require medical treatment for

emergency medical conditions would be considered ‘discrimination’ under [Weldon] if the required medical treatment was abortion-related services.”).

Notwithstanding HHS’s recognition of the “many comments” in the AR “expressing confusion or concern” over how the Rule would interact with EMTALA (and Section 1557), the Rule “does not go into detail as to how its provisions may or may not interact with other statutes or in all scenarios.” 84 Fed. Reg. 23,182-83.¹⁷ Instead, HHS resorts again to the vague reassurance that it intends to “harmon[ize]” EMTALA with the federal conscience statutes “to the fullest extent possible.” *Id.* at 23,183; Mot. 35. That, of course, is what HHS was required to do *before* issuing the Rule. Again, and particularly in light of the Rule’s expansive new definitions, *see* Section I.D.2, *infra*, this does little to alleviate the City’s fear of sanctions and *nothing* to alleviate the threat of interruption of care for the City and its EMS and clinics when providers read the Rule to override the requirement to provide emergency medical care. EMS’s only options are to violate the Rule, on the one hand, or EMTALA, on the other. *See* PI Motion at 19; Declaration of James Matz (Dkt. 14-8) (Matz Decl.) (“There is no way for EMS to accommodate such refusals [to transport patients needing emergency care] without serious risk to the life of the patients and to the public health.”).¹⁸

HHS’s assertion now that this scenario is “hypothetical,” Mot. 35, ignores its own recognition of the “many comments” about this issue in the Rule, 84 Fed. Reg. 23182-83, and the

¹⁷ HHS defends this in the Rule by stating that the 2011 Rule also did not address EMTALA. 84 Fed. Reg. 23,182-83. But neither did the 2011 Rule expand the definition of “assist in the performance” and “discriminate or discrimination” to conflict with EMTALA so the comparison is inapt.

¹⁸ HHS’s citation to its explanation in the 2008 Rule that it is “not aware of any instance where a facility required to provide emergency care under EMTALA was unable to do so because its *entire staff* objected to the service on religious or moral grounds,” Mot. 35 (73 Fed. Reg. 78,087), is willful blindness. As set forth in the Matz Declaration attached to Plaintiff’s PI Motion, a single refusal in the emergency context could be “catastrophic.”

recognition that “EMTALA might apply in a particular case,” *id.* at 23,188. HHS confirmed that the concerns expressed in the comments were warranted: In response to comments seeking to delineate the boundaries of the Rule, HHS suggested, without elaboration, that driving an ambulance *could* come within the new conscience protections. *See id.* at 23,186, 23,188. The AR (ignored by Defendants) confirms the numerous examples of real harms arising in emergency scenarios.

The Rule’s facial conflict with EMTALA is grounds to set the Rule aside under the APA.

D. The Rule is in Excess of Statutory Authority

In addition to being contrary to law, the Rule far exceeds HHS’s statutory authority under the statutes it purports to implement and must be set aside. 5 U.S.C. § 706(2)(A). The Federal Conscience Statutes HHS expands do not provide HHS *any* authority, express or implicit, to expand the substantive rights granted or the agency’s enforcement power. Even if there was some implicit authority or indication that Congress had left a gap to fill—and there is not—HHS’s definitions are contrary to the plain language and legislative intent of the statutes.

1. HHS Lacks Statutory Authority to Expand the Federal Conscience Statutes and Their Enforcement Mechanisms.

HHS’s power to promulgate legislative regulations “is limited to the authority delegated by Congress.” *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988). As a result, it is “incumbent upon [the agency] to demonstrate that some statute confers upon it the power it purport[s] to exercise.” *Cal. Indep. Sys. Operator Corp. v. FERC*, 372 F.3d 395, 398 (D.C. Cir. 2004); *see also Gonzales v. Oregon*, 546 U.S. 243, 258 (2006). The agency must affirmatively demonstrate this by pointing to specific statutory authority. *Am. Petroleum Inst. v. EPA*, 52 F.3d 1113, 1120 (D.C. Cir. 1995). Where an agency acts in excess of statutory authority, courts do not hesitate to vacate the rule in question. *Pharm. Research & Mfrs. of Am. v. U.S. Dep’t of Health &*

Human Servs., 43 F. Supp. 3d 28, 39 (D.D.C. 2014) (finding that stringing together specific grants of authority under the statute did not authorize the rule and vacating rule under *Chevron* step one).

a. HHS lacks statutory authority to expand the substantive scope of the Federal Conscience Statutes.

In contending that it has statutory authority for its expanded interpretations of clear definitions under the Church, Coats-Snowe, and Weldon Amendments, HHS *does not* argue that these self-enforcing statutes give HHS authority. Rather, HHS cobbles together purported authority from *other* statutes relating to enforcement along with general authority to oversee the agency’s internal “housekeeping matters.” Mot. 19-20. HHS asserts conclusorily that Congress “implicitly included a grant of authority to HHS” to issue the Rule and vastly expand the scope of the statutes. *Id.* at 20. HHS then argues that its authority stems from “the interaction” of the Federal Conscience Statutes “with HHS’s authority to impose terms and conditions in its grants contracts, and other funding instruments in its programs.” *Id.* at 21. HHS does not cite a single case in support of its suggestion that authority may be found by compiling separate general delegations of authority. The law says the opposite: HHS *cannot* use general authority to expand the substantive conditions of context-specific, detailed Federal Conscience Statutes. *See Air All. Houston v. EPA*, 906 F.3d 1049, 1061 (D.C. Cir. 2018) (“[I]t is well established that an agency may not circumvent specific statutory limits on its actions by relying on separate, general rulemaking authority.”); *Cal. Indep. Sys. Operator Corp.*, 372 F.3d at 399 (looking at the specific sections cited and concluding that they did not have “anything to do with the authority claimed by [the agency]”); *Pharm. Research & Mfrs. of Am.*, 43 F. Supp. 3d at 39 (vacating rule where “the statutory provisions HHS has strung together to give it rulemaking authority . . . are specific grants of authority that do not authorize the [Rule] implemented here”).

b. HHS lacks statutory authority to give itself sweeping enforcement power over conscience violations.

Under the Rule, HHS arrogated to itself broad enforcement authority found nowhere in the Federal Conscience Statutes, in excess of statutory authority, so the Rule must be set aside. HHS's assertion of "authority to *enforce* the Federal Conscience and anti-discrimination laws," 84 Fed. Reg. at 23,220, is impermissibly based on "grasping at its separate, more general authority." *Air All. Houston*, 906 F.3d at 1061. *See* Mot. 22.

HHS contends that its expansion of its enforcement authority is the same "as HHS does with other civil rights laws within its purview." Mot. 14. But all civil rights laws are not the same. Where Congress desires to confer specific enforcement authority, such as the detailed enforcement provisions in the Rule, it knows how to do so. *See, e.g.*, 42 U.S.C. § 2000d-1 (Title VI), 20 U.S.C. § 1682 (Title IX); 42 U.S.C. § 6104 (Age Discrimination Act); 29 U.S.C. § 794 (Rehabilitation Act of 1973), 42 U.S.C. § 18116(a) (Section 1557 of the ACA). Only one of the numerous statutes HHS purports to implement through the Rule delegates any enforcement authority: Section 1553 of the ACA designates OCR "to receive complaints of discrimination *based on this section*." 42 U.S.C. § 18113(d) (emphasis added). On its face it thus confers on OCR the power to receive complaints *under the ACA's prohibition against discrimination based on refusals related to assisted suicide*. There is no direct grant—under that section or any cited statute—of "robust" enforcement authority that could halt or reverse all federal funding for all the reasons covered by the Rule. 84 Fed. Reg. at 23,254. Far from supporting HHS's expansive view of its own enforcement authority, the many civil rights statutes (and indeed other provisions of the ACA) conferring authority to enforce and to impose restrictions on federal funding weigh against reading that same authority "implicitly" into the Federal Conscience Statutes, which are silent on the subject. *See William v. Gonzales*, 499 F.3d 329, 333 (4th Cir. 2007) (Where Congress "includes

particular language in one section of a statute but omits it in another section of the same Act it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.”) (quoting *Clay v. United States*, 537 U.S. 522, 528 (2003) (alteration omitted)).

This Court should be particularly reluctant to infer such authority where, as here, HHS has brought about “an enormous and transformative expansion in [the agency’s] regulatory authority” through its broad enforcement powers. *Util. Air Regulatory Grp. v. EPA*, 573 U.S. 302, 324 (2014).

Where Congress has not delegated to HHS authority to expand either the substantive conditions of the Federal Conscience Statutes or their enforcement mechanisms. In these circumstances, courts set aside “even reasonable regulations that claim a force of law.” *Motion Picture Ass’n of Am. v. FCC*, 309 F.3d 796, 807 (D.C. Cir. 2002). *See also, e.g., Air Alliance Houston*, 906 F.3d at 1061; *Pharm. Research & Mfrs. of Am.*, 43 F. Supp. 3d at 39. The Court should certainly set aside this unreasonable Rule.

2. The Rule’s Definitions Exceed and Conflict with Congressional Intent.

As detailed in the City’s PI Motion at 13-14, 22-24, the Rule stretches and distorts the clear, carefully delimited statutory terms “health care entity,” “assist in the performance,” and “referral,” to expand the number and character of prospective objectors to essentially any worker performing virtually any task in a healthcare context. And it expands the equally-clear definition of “discrimination” to prevent BCHD and its clinics and programs from learning of and addressing the far-reaching class of objectors and objections under the Rule without disrupting patient care. *See* 84 Fed. Reg. 23,263–64 (to be codified at 45 C.F.R. § 88.2-88.3(a)-(c)).

HHS correctly notes that the City “makes no attempt to argue that the terms of the *Federal Conscience Statutes* are ambiguous, likely because each clearly provides unambiguous notice to funding recipients of the Statutes’ anti-discrimination provisions.” Mot. 50. If a construction of a

statute “‘follows from the unambiguous terms of the statute,’ the statute ‘leaves no room for agency discretion.’” *Sunrise Coop., Inc. v. United States Dep’t of Agric.*, 891 F.3d 652, 656 (6th Cir. 2018) (quoting *Nat’l Cable & Telecomm. Ass’n v. Brand-X Internet Servs.*, 545 U.S. 967, 982 (2005)). “The fact that Congress does not define a term does not mean it is ambiguous.” *Id.* HHS’s own admission confirms that it has no authority to expand the unambiguous terms in the Federal Conscience Statutes.

Even if the Court concludes that HHS had “implicit” authority to issue regulations interpreting the Church, Coats-Snowe, and Weldon Amendments,¹⁹ what HHS now characterizes as “housekeeping,” Mot. 20 is, in fact, a breathtaking expansion of the statutes’ already clear terms “health care entity,” “assist in the performance,” “referral or refer for,” and “discriminate or discrimination” beyond the plain language, beyond any discernable legislative intent, and contrary to existing law.

“Assist in the Performance.” The Rule drastically expands the term “assist in the performance” to include anything—including the vague “making arrangements”—that could be construed as “furthering” a procedure, part of a health service program, or research activity.²⁰ 84 Fed. Reg. at 23,263; Mot. 23. This definition expands the number of prospective objectors to potentially any worker in the healthcare sphere, and HHS exacerbated the uncertainty created by this expansion by refusing to clarify the scope in response to comments. *See id.* at 23186, 23188

¹⁹ No deference is due when the congressional delegation of interpretive authority is not express (HHS concedes there is no express delegation) and there is no indication that Congress left “gaps” to fill. *United States v. Mead Corp.*, 533 U.S. 218, 229 (2001).

²⁰ HHS asks the Court and Plaintiff to take solace in the fact that the Rule carves out objections based on “irrational” and “excessively attenuated” connections between the action objected to and the procedure or program. Mot. 24. But that narrow limitation, which allows attenuated connections as long as they are not “excessively attenuated,” confirms the breadth of this expanded definition, its departure from the plain language of the statute and congressional intent.

(suggesting, but not deciding, that preparing a room for a procedure, scheduling an appointment, or driving an ambulance *could* come within the scope of the Rule).

HHS's self-serving assertion that this expansion, "is necessarily clearer and less ambiguous than the Statutes," Mot. 50, defies common sense (particularly in light of numerous requests to clarify the definition's scope, and HHS's refusal to do so) and HHS reached the opposite conclusion in the 2011 Rule. *See* 76 Fed. Reg. at 9969 ("the 2008 final rule attempting to clarify the Federal health care provider conscience statutes has instead led to greater confusion"). More importantly, this expansion of the definition is inconsistent with Sen. Church's own stated legislative intent. Sen. Church confirmed the statute's limited scope: "The amendment is meant to give protection to the physicians, to the nurses, to the hospitals themselves, if they are religious affiliated institutions There is no intention here to permit a frivolous objection from *someone unconnected with the procedure to be the basis for a refusal to perform what would otherwise be a legal operation.*" 119 Cong. Rec. S9595 (Dec. 22, 1973) (emphasis added). Yet the expanded definition allows exactly that.

Finally, this expansion, which HHS has said may extend to ambulance crews, is among the changes renders the Rule contrary to Congress's intent as expressed in EMTALA and the ACA's prohibitions on regulations interfering with access to care. *See* Section I.C, *supra*. It thus exceeds statutory authority and is contrary to law.

"Health Care Entity." As Defendants recognize, the Coats-Snowe and Weldon Amendments, which relate to abortion, expressly define the term "health care entity," Mot. 27, and each contains a different specific list of "include[d]" individuals and entities. 42 U.S.C. § 238n(2); 42 U.S.C. § 18113. The Rule adds numerous terms to these lists, without any indication that

Congress left any gap or intended these terms to be expanded.²¹ And HHS’s expansions are contrary to legislative intent. For example, the Rule adds to the Coats-Snowe list “other health care professional, including a pharmacist,” and “any other health care provider or health care facility.” But Congress *already* included “other healthcare professional and “any other kind of health care facility” in Weldon and expressly *did not* include it in Coats-Snowe, which indicates Congress did not intend HHS’s expansion. *William*, 499 F.3d at 333.

“Referral or Refer For.” The Rule also expands the terms “referral or refer for” from Weldon, Coats-Snowe, and the ACA (together, limited to abortion and assisted suicide) to include *any* “provision of information” where “the purpose *or reasonably foreseeable outcome* . . . is to assist a person in receiving funding or financing for, training in, obtaining, or performing a particular health care service, program, activity, or procedure.” 84 Fed. Reg. at 23,264 (emphasis added). The Rule’s expansion of *who* is now covered—anyone with a “reasonably foreseeable outcome” of assisting—and *what conduct* is now covered—funding, financing, training, obtaining, performing a service, goes far beyond any intent discernible in the statute.

Coats-Snowe refers specifically to “refer for training in the performance of induced abortions” and expressly identifies the individuals to which the term applies: “individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions.” 42 U.S.C. § 238n. Weldon addresses discrimination on the basis that an entity “does

²¹ HHS relies on *Samantar v. Yousuf*, 560 U.S. 305, 317 (2010) for the proposition that its authority to expand these definitions derives from use of the term “includes,” which, HHS says, shows that the “statutes plainly contemplate a broader group of health care entities than those explicitly listed.” Mot. 28. *Samantar* stated that “use of the word ‘include’ *can* signal that the list that follows is meant to be illustrative rather than exhaustive” but held that “*even if* illustrative rather than exclusive” the statute did not support the expansive definition of “include.” *Id.* Nothing in Coats-Snowe or Weldon suggest that “includes” was illustrative as opposed to defining the outer scope of the term “health care entity” or each specific statute.

not provide, pay for, provide coverage of, or refer *for abortions*.” Consolidated Appropriations Act of 2009, Pub. L. No. 111-117, § 508(d)(1), 123 Stat. 3034. The plain and highly specific language in these statutes forecloses any finding that Congress intended to delegate authority to expand the term “refer for training” or “refer for abortions” as HHS has done. *Nat’l Cable & Telecomm. Ass’n.*, 545 U.S. at 982 (where construction “follows from the unambiguous terms of the statute,” the statute “leaves no room for agency discretion.”).

“Discriminate or Discrimination.” The Rule’s expansive definition of “discriminate or discrimination” also goes well beyond the specific and plain language, which gives no indication that Congress left any “gap” to fill. Even if there were such authority the definition’s stringent restrictions on healthcare providers’ ability to accommodate objections and ensure continuity and quality of care, are unsupported by discernible intent in the Federal Conscience Statutes (HHS points to nothing). *See* PI Motion at 37-47 (describing harms to the City arising from the expansive definition of discrimination). And HHS’s expanded definition is directly contrary to express Congressional intent in the ACA and EMTALA, among other statutes, to ensure that conscience objections do not adversely affect patient care. *See* Section I.C, *supra*.

HHS seeks to avoid review of its expansive definition by saying it applies only “to the extent permitted by the applicable statute” and therefore the definition “does not exceed Congress’s intent because it explicitly *cannot* exceed Congress’s intent.” Mot. 25-26 (quoting 84 Fed. Reg. at 23,263) (emphasis in original). This is no protection at all because HHS has given itself authority to enforce the Rule and, thus, to determine what the statute permits. If HHS could avoid scrutiny under the APA by simply saying that clear expansions of statutory text apply only to the extent allowed by the statute, the APA would be a nullity. In any event, as discussed in Section I.C, *supra*, HHS’s assertion of fidelity to statutes (Mot. 26 (quoting 84 Fed. Reg. at

23,192)) is belied by the agency’s straightforward abrogation of the essential patient protections that Congress expressly wrote into the ACA and EMTALA.

Nothing in the Federal Conscience Statutes authorizes HHS to give absolute priority to the religious views of objecting employees over the rights that Congress specified for patients to receive medically appropriate and nondiscriminatory healthcare services or over the ability of the City, its programs, and its contractors and grantees to provide those services. Yet that is exactly what HHS has done. *See* Mot. 26 (to avoid being “under-inclusive,” HHS established a “non-exhaustive list of examples” far broader than anything found in any statute that “could” constitute discrimination; and to avoid being “over-inclusive,” it includes “three provisions” limiting providers’ abilities to make accommodations to far less than what Title VII requires²² or the ACA and EMTALA allow).

HHS’s arrogation to itself of significantly expanded enforcement authority and its expansion of definitions beyond any conceivable delegation of authority directly contravene legislative intent. The Court should vacate the Rule on this ground.

E. The Rule is Unconstitutional.

Agency action is invalid under the APA if it is contrary to constitutional right, power, privilege, or immunity. 5 U.S.C. § 706(2)(B). The Rule violates the Constitution’s Establishment Clause and Spending Clause and is therefore invalid.

1. The City’s constitutional claims are ripe.

HHS challenges the ripeness of the City’s APA claim that the Rule violates the Spending

²² HHS also expressly declined to incorporate in the Rule’s definition of “discriminate and discrimination” the “undue hardship” exception generally applicable to employers under Title VII because, it says, Congress did not expressly incorporate that requirement in the conscience statutes. 84 Fed. Reg. 23,191. But Congress also did not place any further restriction on the requirement to make only *reasonable* accommodations for religious objectors.

and Establishment Clauses. Mot. 16–19. However, the APA provides a *single* cause of action for challenging final agency action, *see* 5 U.S.C. § 704, thus, if the City presents any ripe APA challenge to the Rule, and it does, as set forth in Section I.A, *supra*, any of the enumerated methods under § 706(2) for proving that the agency’s action was unlawful are available if warranted by the evidence. *Abbott Labs v. Gardner*, 387 U.S. 136, 149 (1967) (superseded on other grounds by statute, Pub. L. 94-574, 90 Stat. 2721); *see also MedImmune, Inc. v. Genentech, Inc.*, 549 U.S. 118, 128 n.8 (2007). Allowing HHS to parse theories of recovery under a single cause of action would effectively violate the rule barring claim-splitting. *Sensormatic Sec. Corp. v. Sensormatic Elecs. Corp.*, 452 F. Supp. 2d 621 (D. Md. 2006).

Whether a rule runs afoul of the APA by violating the Spending and Establishment Clauses is a purely legal question and is thus ripe for adjudication. *Abbott Labs.*, 387 U.S. at 149. Review is ripe when, as here, (1) delayed review causes hardship to the plaintiff; (2) judicial intervention does not inappropriately interfere with administrative action; and (3) further factual development is unnecessary. *Ohio Forestry Ass’n v. Sierra Club*, 523 U.S. 726, 733 (1998). *Accord Miller v. Brown*, 462 F.3d 312, 319 (4th Cir. 2006) (challenge to Virginia open primary law ripe where there was no suggestion that law would not be enforced, plaintiffs would suffer hardship by having to wait until eve of election, and final decision would allow plaintiffs to plan).

First, a judicial challenge to a regulation is ripe when the rule requires parties to comply with new restrictions or risk serious penalties. *Abbott*, 387 U.S. at 152. Absent court intervention, the Rule will go into effect on November 22, 2019. The City brings these claims now because it must decide—now—whether to forgo federal funding with potentially devastating consequences, or else rewrite existing policies, change its operations, incur additional costs and administrative burdens, and certify compliance. The City cannot afford to carry the unacceptable risk of an

unbudgeted termination of huge swaths of federal funding. Nor can it, consistent with its legal and ethical duties and the Health Department’s mission, take a “wait and see” approach to deciding how to handle refusals while also ensuring timely, adequate, and compassionate care. As a governmental entity charged with protecting the public health, the City bears special responsibility to ensure continuity in the provision of public health services and care for vulnerable populations and the indigent.

Delayed review here would result in “substantial hardship.” *See Pac. Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm’n*, 461 U.S. 190, 201 (1983). The Rule’s immediate compliance requirements and assurance and certification requirements, 45 C.F.R. § 88.4(a)(3), (5), obligate recipients and sub-recipients to comply throughout the duration of funding as a condition of continued receipt of funds. 84 Fed. Reg. at 23,269. Thus, the City will be forced midway through the fiscal year either to disrupt its budgetary plans in order to comply with requirements that have an immediate and deleterious effect on the governance and functioning of the BCHA, its programs, and the patients that it serves, or else continue to provide services as it always has—believing in good faith that it meets all statutory requirements—but risk losing funding nonetheless. PI Motion at 37-46. BCHA’s clinics and EMS will also need to examine and alter their policies immediately. *See id.* at 7-8 (listing clinics). And the Rule targets the City’s commitment to providing reproductive healthcare and LGBTQ healthcare. *See id.* at 4-5, 20. Thus, the effects of the Rule will be felt immediately because the City will need to alter its day-to-day affairs immediately to comply. *See* 84 Fed. Reg. at 23,180 (“[R]ecipients are responsible for their own compliance with Federal conscience and anti-discrimination laws and implementing regulations, as well as for ensuring their sub-recipients comply with these laws.”). “Agency regulations can sometimes force immediate compliance through fear of future sanctions,” *Ohio Forestry Ass’n*, 523 U.S. at 734,

which is exactly what the Rule does. *See also Nat'l Park Hosp. Ass'n v. Dep't of Interior*, 538 U.S. 803, 808 (2003) (concluding that requiring plaintiffs to adjust their conduct immediately is the “major exception” to the presumption that a regulation is unripe).

HHS’s reliance on *National Family Planning & Reproductive Health Ass’n v. Gonzales* is misplaced. The plaintiffs in *Gonzales* did not face any immediate regulatory burdens; whereas here, the expanded definitions of such terms as “discrimination,” “assist in the performance,” and “refer” provide precisely the basis for review lacking in *Gonzales*. Here, a recipient’s decision to do something as simple as reassigning an employee could be “transform[ed]” into an act of discrimination subject to enforcement and de-funding, 468 F.3d 826, 828–30 (D.C. Cir. 2006); accord *California v. United States*, 2008 WL 744840, at *4 (N.D. Cal. Mar. 18, 2008) (no clear indication that enforcing EMTALA to require medical treatment for emergency medical conditions would be considered “discrimination” under the Weldon Amendment if the required medical treatment was abortion-related service).

Miller v. Brown, 462 F.3d 312 (4th Cir. 2006), provides no support for HHS’s ripeness challenge and, in fact, underscores why the City’s APA claim is ripe.²³ As indicated, it is the immediate compliance demands, the immediate negative effect on long-term efforts (and progress) in eradicating stigma from the City’s public health system, and the immediate setback to the City’s holistic, trauma-informed approach to its public health mission that are at stake when the Rule takes effect. PI Motion at 37-43. Moreover, that the Rule “causes immediate harm to . . .

²³ HHS argues that “the mere existence of the Rule,” Mot. 18, cannot cause undue hardship—a position that is plainly wrong. When, as here, a Rule requires compliance on threat of withdrawal of all federal funding, the undue coercion prohibited by the Spending Clause immediately, because the requirement to elect whether to continue to accept funds that are conditioned on compliance is itself immediate, and ongoing.

constitutionally protected rights,” *Miller*, 462 F.3d at 321, weighs clearly in the City’s favor under the undue-hardship component of the ripeness test.

Second, judicial action will not inappropriately interfere with administrative action because the Rule has not yet gone into effect. Mot. at 18. But even if there were, this case presents purely legal questions regarding HHS’s authority to issue the Rule and the propriety of the Rule’s expansive reach. *See, e.g., Texas v. United States*, 201 F. Supp. 3d 810, 824 (N.D. Tex. 2016) (rejecting assertion that administrative action should block judicial review where issues were purely legal and defendants asserted noncompliance with their interpretation). In all events, can there realistically be any expectation that the City has any choice but to comply?

Third, factual development is unnecessary. In *Texas v. United States*, 523 U.S. 296, 300 (1998), the Supreme Court concluded that “contingent future events” do *not* necessarily make a matter unripe; if that were so, “virtually all pre-enforcement cases would be non-justiciable on prudential ripeness grounds.” The “contingent future events” in *Texas* were that Texas had “no idea of whether or when” the state law would be enforced, rendering the triggering of federal enforcement action uncertain. *Id.* at 299–300. Here, by contrast, HHS has made clear that it promulgated the Rule to foster “robust” enforcement.²⁴ 84 Fed. Reg. at 23,179. Further, the City must immediately make policy and staffing changes to comply with the Rule and provide assurances and certifications as soon as they reapply for or alter their federal grant funding. Mot. 13. This APA challenge to the Rule is ripe for judicial review.

²⁴ HHS also clearly states that it intends “to investigate violations of, and to enforce, federal conscience and anti-discrimination laws,” whether under the new Rule, or under the prior 2011 rule, or directly under the supposedly authorizing statutes themselves. Mot. 57.

2. The Rule violates the Establishment Clause.

The Establishment Clause safeguards religious freedom by barring official conduct that favors one faith over others or religion over nonreligion, advances or endorses religion, coerces religious belief or practice, or excessively entangles government with religion. *See, e.g., McCreary Cty. v. ACLU of Ky.*, 545 U.S. 844, 860 (2005); *Lee v. Weisman*, 505 U.S. 577, 587 (1992); *Edwards v. Aguillard*, 482 U.S. 578, 584–85 (1987); *Mellen v. Bunting*, 327 F.3d 355, 370–71 (4th Cir. 2003). The Rule is irreconcilable with these constitutional guarantees, and therefore should be vacated under 5 U.S.C. § 706(2)(b), principally because it elevates the religious beliefs of objectors over the rights, beliefs, and interests of providers, patients, and the public health, and because it coerces religious exercise by requiring the City, the public-health programs that it operates or funds, and the patients that those programs serve, all to act in accordance with objecting employees’ religious beliefs. It also subjects the City’s insureds to stigmatizing denials of care, in the name of elevating health care workers’ “religious, moral, ethical or other” beliefs over the beliefs of the insured patients themselves.

a. The Rule impermissibly favors religion by imposing costs and burdens of objecting employees’ religious beliefs on the City, its residents, and other third parties.

“The principle that government may accommodate the free exercise of religion does not supersede the fundamental limitations imposed by the Establishment Clause.” *Weisman*, 505 U.S. at 587. In that regard, governmental accommodations of religion are permissible only if, among other constitutional requirements, they do not detrimentally affect third parties. *See, e.g., Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 726–27 (2014); *Cutter v. Wilkerson*, 544 U.S. 709, 720 (2005). For if the government materially burdens or harms third parties when accommodating religious beliefs or exercise, it impermissibly prefers the religion of those who are benefited over the rights and interests of those who are burdened. *See, e.g., Texas Monthly, Inc. v. Bullock*, 489

U.S. 1, 15 (1989) (plurality opinion); *Estate of Thornton v. Caldor*, 472 U.S. 703, 710 (1985) (The Establishment Clause “gives no one the right to insist that in pursuit of their own interests others must conform their conduct to his own religious necessities.” (quoting *Otten v. Baltimore & Ohio R. Co.*, 205 F.2d 58, 61 (2d Cir. 1953) (Hand, J.))). Thus, in *Caldor*, the Supreme Court invalidated a state law requiring employers to accommodate Sabbath observers in all instances, because “the statute t[ook] no account of the convenience or interests of the employer or those of other employees who do not observe a Sabbath,” thus impermissibly “command[ing] that . . . religious concerns automatically control over all secular interests at the workplace.” *Id.* at 709.²⁵

Yet that is precisely what the Rule does. The Rule “imposes on employers and employees an absolute duty to conform their business practices to the particular religious practices of the employee,” *id.*, requiring the City to accede to all religious objections regardless of the circumstances, and thereby curtailing the City’s ability to ensure that accommodation of objections does not compromise the management of its health programs or disrupt patient care. The Rule does so by, among other requirements, drastically limiting the City’s ability even to ask about and plan

²⁵ In *Texas Monthly*, the Court invalidated a tax exemption for religious periodicals because it “burden[ed] nonbeneficiaries markedly” and hence “provide[d] unjustifiable awards of assistance to religio[n]” that “cannot but conve[y] a message of [religious] endorsement” by “increasing [nonbeneficiaries’] tax bills by whatever amount is needed to offset the benefit bestowed on subscribers to religious publications.” 489 U.S. at 15, 18 n.8 (plurality opinion) (internal quotation marks omitted). In *Hobby Lobby*, all nine Justices authored or joined opinions recognizing that harmful effects on nonbeneficiaries must be considered in evaluating religious accommodations. 573 U.S. at 693, 726-27; *id.* at 739 (Kennedy, J., concurring); *id.* at 745-46 (Ginsburg, J., dissenting, joined by Breyer, Kagan, and Sotomayor, JJ.); *see also Cutter*, 544 U.S. at 720 (concluding unanimously that, for Religious Land Use and Institutionalized Persons Act to be constitutional, it must be interpreted to require courts to “take account of the burdens a requested accommodation may impose on nonbeneficiaries”); *United States v. Lee*, 455 U.S. 252, 261 (1982) (rejecting Amish employer’s request under Free Exercise Clause for religious exemption from paying social-security taxes where exemption would impermissibly “operate[] to impose the employer’s religious faith on the employees”); *Sherbert v. Verner*, 374 U.S. 398, 409 (1963) (in concluding that religious exemption for Sabbatarian was permissible, recognizing that requested accommodation would not “abridge any other person’s religious liberties”).

for potential religious objections, 84 Fed. Reg. at 23,263, permitting only voluntary transfers or scheduling changes for objecting employees even when the City does learn about the objections, *id.*; requiring the City to reassign other employees to cover the work that objecting employees refuse to perform and imposing on the City the resulting costs and burdens of double-staffing (assuming, of course, that those other employees do not themselves have religious objections), *id.*; *see also, e.g.*, Greenbaum Decl. ¶ 73; Dineen Decl. ¶ 80; and ultimately allowing patients to be denied needed care and information required for informed consent, 84 Fed. Reg. at 23,263–23,265. *see also* PI Motion at 39-43 (detailing harms to patients).

Consistent with federal, state, and local law, and in keeping with medical ethics and standards of care, the City already maintains policies that respect and accommodate employees’ religious beliefs without harming patients or other employees and without compromising the City’s public-health mission. *See* Dzirasa Decl. ¶¶ 15–19. The Rule would supplant these policies and absolutely “relieve [workers] of the duty to work” whenever they have a religious reason for not wanting to perform even essential job duties, “no matter what burden or inconvenience this imposes on the employer or fellow workers”—or on patients. *Caldor*, 472 U.S. at 708–09. And the detrimental effects that flow from the Rule’s elevation of the religious beliefs of objecting employees above all else are serious and unremitting. They include burdens on *other* employees; costs and other burdens on the City’s ability to operate and manage its health programs; harms to the City’s mission to protect the public health, eliminate disparities in healthcare outcomes, and ensure the well-being of Baltimore’s 600,000 residents; and ultimately costs and adverse health outcomes to the vulnerable Baltimore residents who rely on the City’s healthcare services. *See, e.g.*, Dzirasa Decl. ¶¶ 25–28, 31; Greenbaum Decl. ¶¶ 40, 83–86; Dineen Decl. ¶¶ 2, 81–89; Matz Dec. ¶¶ 9–16 (describing irreparable harms to City’s health care system).

Put simply, the Establishment Clause does not permit this cavalier disregard of the burdens on nonbeneficiaries when purporting to accommodate religious objectors. And the burdens here are far more severe than those that required invalidation of the religious accommodations in *Caldor* and *Texas Monthly*. By requiring the City to “adjust [its] affairs to the command of the [federal government] whenever [the Rule] is invoked by an employee,” *Caldor*, 472 U.S. at 709, the Rule violates the Establishment Clause.

The cases that HHS cites, Mot. 44-47, do not alter the controlling constitutional standards. In *Kong v. Scully*, 341 F.3d 1132 (9th Cir. 2003), the accommodation did not harm patients or burden anyone else but: The court upheld a law allowing medical reimbursements to healthcare institutions for “the nonmedical care of persons whose religious tenets lead them to reject medical services.” *Id.* at 1134. *Chrisman v. Sisters of St. Joseph of Peace*, 506 F.2d 308 (9th Cir. 1974), upheld a provision of the Church Amendments ensuring that federal funding could not be used to compel a hospital to perform medical procedures against its religious mission, emphasizing that the provision preserved governmental “neutrality” with respect to religion. *Id.* at 311. The statute did not, as the Rule does here, give special privileges to religion or prefer particular religious views.²⁶ *Doe v. Bolton*, 410 U.S. 179, 198 (1973) held only that also requiring hospitals to establish a committee to approve abortions was unduly restrictive of patients’ rights. And *Corporation of the Presiding Bishop of the Church of Latter-Day Saints v. Amos*, 483 U.S. 327, 339 (1987), supports the City, underscoring that the Establishment Clause forbids government to “give[] the force of law to” employees’ religious views “by requir[ing] accommodation by the employer

²⁶ That *Chrisman* or any other case may have upheld a statute that the Rule invokes is of no moment. The City does not challenge the statutes’ constitutionality but rather objects to HHS’s unbridled expansion of those statutes’ reach in ways that cannot be squared with Establishment Clause proscriptions or, indeed, with decisions upholding any statute.

regardless of the burden which that constitute[s] for the employer or other employees,” or for patients.²⁷

b. The Rule impermissibly advances and endorses certain religious beliefs by accommodating those beliefs in the absence of substantial, government-imposed burdens on them.

The Rule also violates the Establishment Clause because the government may require accommodation of religion only to alleviate substantial government-imposed burdens on religious practice. *Cutter*, 544 U.S. at 720; *Cty. of Allegheny v. ACLU Greater Pittsburgh Chapter*, 492 U.S. 573, 613 n.59 (1989); *Texas Monthly*, 489 U.S. at 15 (plurality opinion). When there is no “exceptional government-created burden[] on private religious exercise,” or when the government goes beyond what is needed to alleviate the burdens that it, itself, has imposed, *see Cutter*, 544 U.S. at 720, its action crosses the line of permissible religious accommodation and “devolve[s] into ‘an unlawful fostering of religion,’” *Amos*, 483 U.S. at 334–35 (quoting *Hobbie v. Unemployment Appeals Comm’n*, 480 U.S. 136, 145 (1987)).

Thus, although the federal government may “lift[] a regulation that burdens the exercise of religion,” *id.* at 338, when it has imposed that burden to begin with, it may not broadly and absolutely compel the City to afford special solicitude to religion, *see, e.g., City of Boerne v. Flores*, 521 U.S. 507, 532–33, 536 (1997).

²⁷ *Amos* concerned a church’s firing of an employee who was not in religious good standing. The exemption from Title VII’s prohibition against religious discrimination did not amount to unconstitutional religious favoritism because it avoided interference with church autonomy and internal church governance—core concerns under both the Establishment and Free Exercise Clauses that are not implicated when, as here, the regulated entities are not churches. *See Real Alternatives, Inc. v. Sec’y Dep’t of Health & Human Servs.*, 867 F.3d 338, 352 (3d Cir. 2017). As HHS acknowledges, Mot. 46, any harm to the employee in *Amos* resulted from the church’s actions, not the government’s, 483 U.S. at 337 & n.15. Here, it is the Rule, and hence the federal government, that causes the harms.

Additionally, religious exercise is substantially burdened—and therefore may be subject to accommodation—only if the government “compel[s individuals] to engage in conduct proscribed by their religious beliefs . . . [or] force[s them] to abstain from any action which their religion mandates that they take.” *Goodall ex rel. Goodall v. Stafford Cty. Sch. Bd.*, 60 F.3d 168, 172–73 (4th Cir. 1995) (applying Religious Freedom Restoration Act); *see also Lyng v. Nw. Indian Cemetery Protective Ass’n*, 485 U.S. 439, 449 (1988) (religious exercise is burdened only when individuals are “coerced by the Government’s action into violating their religious beliefs” or when “governmental action penalize[s] religious activity by denying any person an equal share of the rights, benefits, and privileges enjoyed by other citizens”). Merely asserting that an action is religiously motivated does not make the action religious exercise, much less does it demonstrate a legally cognizable substantial burden on that exercise. *See, e.g., Hernandez v. Comm’r*, 490 U.S. 680, 698–99 (1989); *Henderson v. Kennedy*, 253 F.3d 12, 16–17 (D.C. Cir. 2001); *Dole v. Shenandoah Baptist Church*, 899 F.2d 1389, 1397–98 (4th Cir. 1990). The Rule is unconstitutionally expansive because it affords religious accommodations for objections that are merely religiously motivated. To comport with the Establishment Clause, the Rule would need at the very least to provide for individualized assessments to determine whether an objector’s religious exercise is genuinely at issue and, if so, whether it is substantially burdened as a legal matter. The Rule, however, does none of that.

Finally, the Rule specially favors and protects certain denominations’ religious beliefs in opposition to reproductive freedom and LGBTQ rights over faiths that hold alternative views on those subjects. It thus constitutes a denominational preference, triggering strict scrutiny and requiring that the Rule be invalidated. *See Larson v. Valente*, 465 U.S. 228, 246 (1982).

c. The Rule impermissibly coerces patients and healthcare providers to adhere to the government's favored religious practices.

“It is beyond dispute that, at a minimum, the Constitution guarantees that government may not coerce anyone to support or participate in religion or its exercise,” *Weisman*, 505 U.S. at 587, for “the machinery of the State” must not be used “to enforce a religious orthodoxy,” *Santa Fe Indep. Sch. Dist. v. Doe*, 530 U.S. 290, 312 (2000). *See also, e.g., Inouye v. Kemna*, 504 F.3d 705, 712–13 (9th Cir. 2007) (conditioning probation on participating in addiction-treatment program with substantial religious content coerced religious activity in violation of Establishment Clause); *Mellen*, 327 F.3d at 371–72 (mealtime prayers at military college unconstitutionally coerced cadets into participating in religious exercise); *Doe v. Phillips*, 81 F.3d 1204, 1210 (2d Cir. 1996) (conditioning dropping criminal charges on defendant’s swearing his innocence on Bible in church was unconstitutional coercion of religious act).

Far from “simply “encourag[ing]” nondiscrimination, Mot. 46, the Rule employs the immense federal regulatory-enforcement authority and the threat of withholding or clawing back all federal funds—roughly half of BCHD’s and EMS’s budgets—to coerce the City to adhere to the religious beliefs and practices of every objecting employee. And in doing so, it forces the City, the providers that it employs and with whom it contracts to perform healthcare services, and the Baltimore residents who depend on those services—often as a matter of last resort—to live in accordance with the objecting employees’ religious preferences. This the Establishment Clause forbids.

Relatedly, when government enforces religious requirements, it impermissibly entangles itself with religion. *See, e.g., Larkin v. Grendel’s Den, Inc.*, 459 U.S. 116, 126–27 (1982); *Barghout v. Bureau of Kosher Meat & Food Control*, 66 F.3d 1337, 1342 (4th Cir. 1995). The Rule not only makes federal and state law and City policies subservient to certain religious views,

but it also vests in federal bureaucrats the authority to impose their preferred religious beliefs through discretionary enforcement. HHS and its staff thus become arbiters of religious doctrine, which the Establishment Clause forbids.

3. The Rule violates the Spending Clause.

Under the Spending Clause, U.S. Const., art. I, § 8, cl. 1, Congress may not impose conditions on federal funds that are (1) so coercive as to compel (rather than merely encourage) States to comply, (2) ambiguous, (3) retroactive, or (4) unrelated to the federal interest in a particular program. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 575–82 (2012); *South Dakota v. Dole*, 483 U.S. 203, 206–08 (1987). The Rule violates all four of these prohibitions because it puts the City at risk of ruinous sanctions as HHS wields the authority that it has now arrogated to itself to terminate, deny, or withhold federal funds. 45 C.F.R. § 88.7(i)(3)(iv)–(v).

HHS erroneously contends that the City is challenging the underlying statutes. Mot. 47–48. Not true. Rather, the City challenges HHS's massive expansion of them via an invalid rule.

a. The Rule is unconstitutionally coercive.

In *NFIB*, the Supreme Court explained that because “Medicaid spending accounts for over 20 percent of the average State’s total budget, with federal funds covering 50 to 83 percent of those costs,” and because States “have developed intricate statutory and administrative regimes” in reliance on receiving that funding, the threatened loss of the funding impermissibly affords recipients “no real option but to acquiesce.” *Id.* at 581–82. Here, the Rule is even more coercive than the threatened loss of Medicaid funding in *NFIB*.

Because federal funding accounts for approximately 50% of BCHD’s budget and 75% of EMS’s budget, the threatened loss of federal funding leaves the City “with no real option but to acquiesce.” *Id.* at 581–82. The Rule threatens not only Medicaid funding, as in *NFIB*, but all federal funding, under a vast array of health, education, and employment programs, including over

half the funds for BCHD and EMS. *Id.* at 581–82. *See* Dzirasa Decl. ¶ 3; Greenbaum Decl. ¶ 22; Dineen Decl. ¶ 28; Matz Decl. ¶ 6. Hence, the Rule violates the Spending Clause: Congress may not “penalize [recipients] that choose not to participate in [a] new program by taking away their existing . . . funding.” *NFIB*, 567 U.S. at 585.

The Rule’s unbounded enforcement authority, *see* 84 Fed. Reg. at 23,272, expands the Weldon Amendment’s consequences (limited in Weldon to abortion) to two dozen now-expanded federal conscience laws across the range of healthcare services. Together with the vague scope of the Rule’s mandate, this multiplies the Rule’s coercive effect. Given the tens of millions of dollars in funding at stake, the loss of which would decimate the delivery of healthcare to the residents of one of the country’s most vulnerable cities, the Rule constitutes “economic dragooning” rather than “relatively mild encouragement” to comply. *See NFIB*, 567 U.S. at 581–82. For that reason, the Rule is unconstitutionally coercive.

Indeed, HHS itself previously recognized the constitutional problem that would arise if, in the name of enforcing long-standing and carefully limited federal conscience laws, the federal government asserted sweeping new authority to strip states of funding, as it has done here.²⁸ This Court should recognize the same and hold that the Rule is unconstitutionally coercive.

b. The Rule is unconstitutionally ambiguous.

If Congress desires to condition the City’s receipt of federal funds, it “must do so unambiguously.” *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). Because “[t]here can, of course, be no knowing acceptance [of federal funds] if a State is unaware of the conditions or is unable to ascertain what is expected of it,” *id.*, courts evaluate statutes “from the perspective of a state official who is engaged in the process of deciding whether the State should

²⁸ *See* Ex. 50, AR546807.

accept [the] funds and the obligations that go with those funds.” *Arlington Cent. Sch. Dist. Bd. Of Educ. v. Murphy*, 548 U.S. 291, 296 (2006).

Contrary to HHS’s contention that the Rule merely “mirror[s]” existing federal law, 84 Fed. Reg. at 23,222, it greatly expands the power of objectors to deny care via the Rule’s apparently unbounded definitions, which are untethered from prior constructions of the supposedly authorizing Federal Conscience Statutes. HHS concedes that the Spending Clause demands that States be on clear notice as to their federal obligations. Mot. 50. The Rule fails that test. For example, it purports to allow any “health care personnel” to refuse to provide medical care or to perform any action that has an “articulable connection” to furthering a medical procedure on the basis of religious, moral, ethical, or “other reasons.” How attenuated can the articulable connection to the medical service the patient seeks be to qualify for objection under the Rule? What is an acceptable “other reason”? 84 Fed. Reg. at 23,263. HHS compounds this ambiguity in responding to comments seeking clarity about the Rule’s scope by saying that the issues must be resolved on a case-by-case basis depending on the facts and circumstances. *Id.* at 23,188, 23,189, 23,205. The City cannot make knowing choices about whether to continue to accept federal when HHS refuses to make clear what those limitations are.

In addition, the Rule makes the City responsible for policing its subgrantees’ compliance. 84 Fed. Reg. at 23,180 (“[R]ecipients are responsible for their own compliance with Federal conscience and anti-discrimination laws and implementing regulations, as well as for ensuring their sub-recipients comply with these laws.”). Thus, the City could be found in violation of the Rule if a sub-grantee is found in violation, regardless of whether the City was put on notice of the conduct at issue. The Spending Clause does not allow that outcome. *See Smith v. Metro. Sch. Dist. Perry Twp.*, 128 F.3d 1014, 1030 (7th Cir. 1997) (holding that “[t]o impute liability to a program

or activity” based on one person’s actions “even if [the governmental entity] acted without notice” of the person’s actions “cannot be used to support a monetary award in a Spending Clause case”); *Rosa H. v. San Elizario Indep. Sch. Dist.*, 106 F.3d 648, 654 (5th Cir. 1997) (“As a statute enacted under the Spending Clause, Title IX should not generate liability unless the recipient of federal funds agreed to assume the liability.”).²⁹ Terminating the City’s funding based on the conduct of third-party subgrantees, as the Rule purports to do, would create so unsure a stream of funding that it would be financially paralyzing for the City. *See* Greenbaum Decl. ¶¶ 76–78 (discussing City’s reliance on small sub-grantees).

HHS’s reliance on *West Virginia Department of Health & Human Resources v. Sebelius*, 649 F.3d 217 (4th Cir. 2011), misses the mark. There, West Virginia appealed an adjudication of overpayment under existing rules that allow CMS to recover overpayments under the Medicaid program. At issue was the agency’s application of an existing rule to a specific set of facts, not a pre-enforcement challenge to an underlying new rule itself. Here, HHS’s Rule is clearly assailable on its face as an unprecedented expansion in scope as to who may assert objections, as to which patients or health services may be subject to those objections, and as to which recipients may be liable. The Rule goes far beyond merely lacking “flawless precision.” *Id.* at 223.

c. The Rule imposes unconstitutionally retroactive conditions.

The federal government cannot “surpris[e] participating States with post-acceptance or ‘retroactive’ conditions.” *NFIB*, 567 U.S. at 582–83. Yet the Rule does just that.

²⁹ By contrast, in the Title IX context, a recipient of federal funding cannot be held vicariously liable for harassment perpetrated by its employee if it was not on notice of the harassment. *See Franklin v. Gwinnett Cty. Pub. Sch.*, 503 U.S. 60, 74–75 (1992) (holding school vicariously liable for teacher’s harassment of student because it was on notice of teacher’s discrimination and took no action); *Smith*, 128 F.3d at 1030.

Congress conferred on HHS no authority to “alter, amend, or repeal” the federal conscience laws. *Cf.* Mot. 51. Nevertheless, the agency seeks to override the existing federal conscience-protection framework, dramatically expanding not only those who are covered but also what activities are considered protected and how the laws are enforced. For example, Weldon, Church, and Coats-Snowe refer only to specific circumstances in which healthcare providers or certain enumerated healthcare entities may not be required to participate in abortions, sterilizations, or certain health-service programs and research activities. But the Rule greatly expands the scope of the circumstances under which the federal conscience laws apply. This is a transformation in kind, not degree.

City agencies accept and plan for the receipt of federal funding with the expectation that they will receive the funds under existing grant agreements—in accordance with the terms and conditions of existing federal programs. *See, e.g.*, Greenbaum Decl. ¶ 73 (“The new Rule will be costly and difficult, and in some respects even impossible, for the Bureau of Clinical Services & HIV/STD Prevention Services to implement.”); *id.* ¶ 26 (“Clinical Services does not presently have a staff member assigned to ensure compliance with the terms and conditions of these subgrants.”); *Healthy Teen Network v. Azar*, 322 F. Supp. 3d 647, 654–55 (D. Md. 2018) (noting that multi-year agreements “give the grantee organization some assurance that . . . they can plan for the necessary staff and facilities to carry out the grant’s purpose”).

Without federal funding, BCHD and EMS would have to carry out debilitating reductions in staffing, programs, and services. *See* Dzirasa Decl. ¶ 31; Matz Decl. ¶ 12. Should the City continue to rely upon federal funds for public health programs its situation remains untenable because HHS insists that it will define what constitutes a violation of the Rule only after the fact, in retrospective enforcement proceedings.

d. The conditions on funding are unrelated to conscience objections.

The Spending Clause requires that funding conditions “bear some relationship to the purpose of the federal spending,” *New York v. United States*, 505 U.S. 144, 167 (1992), and be “reasonably calculated” to address the “particular . . . purpose for which the funds are expended,” *Dole*, 483 U.S. at 208–09. “Conditions on federal grants might be illegitimate if they are unrelated to the federal interest in particular national projects or programs.” *Id.* at 207 (internal quotation marks omitted).

The Rule places various federal grants and reimbursements—such as those for HIV/STD prevention, emergency healthcare and transport, and reproductive healthcare—at risk even though the purposes of those grant programs and the statutes that authorize them are wholly unrelated to the protection of conscience objections. The Rule purports even to jeopardize funding for the City’s labor and educational programs—programs with no relationship whatsoever to the Rule’s healthcare conscience restrictions. 76 Fed. Reg. at 9970; 83 Fed. Reg. at 23,170, 23,172.³⁰

II. HHS’s Violations of the APA Require Holding the Rule Unlawful and Vacating and a National Injunction is Necessary to Preserve the Status Quo Until the Law Can be Set Aside.

The Court should declare unlawful and vacate the Rule because it is arbitrary and capricious, in excess of authority, contrary to law and unconstitutional. 5 U.S.C. § 706(2)(A)-(B); *Regents of Univ. of Cal. v. U.S. Dep’t of Homeland Sec.*, 908 F.3d 476, 511 (9th Cir. 2018) (“[W]hen a reviewing court determines that agency regulations are unlawful, the ordinary result is that the rules are vacated—not that their application to the individual petitioners is

³⁰ See Ex. 50, AR546807 (HHS OCR 2016 letter stating: “A finding that [entity] has violated the Weldon Amendment might require the government to rescind all funds appropriated under the Appropriations Act to the State of California—including funds provided to the State not only by HHS but also by the Departments of Education and Labor, as well as other agencies.”)

proscribed.”);

Alternatively, if the Court cannot so rule before the Rule’s November 22, 2019 effective date, the Court should grant a brief national injunction until final judgment is entered, to “protect the status quo and to prevent irreparable harm during the pendency of a lawsuit ultimately to preserve the court’s ability to render a meaningful judgment on the merits.” *In re Microsoft Corp. Antitrust Litig.*, 333 F.3d 517, 525 (4th Cir. 2003) (abrogated on other grounds). Otherwise, the City “is likely to suffer irreparable harm without the preliminary injunction [and because] the injunction is in the public interest.” *Mountain Valley Pipeline, LLC v. W. Pocahontas Properties Ltd. P’ship*, 918 F.3d 353, 366 (4th Cir. 2019).³¹

HHS’s only response to the extensive evidence of imminent harm in the City’s PI Motion and accompanying declarations is to say that the harms are “purely speculative” because “[e]ntities may make accommodations ... if the individual is willing to do so.” Mot. 53. Of course, this assumes that the individual is willing *and* that an accommodation is available, neither of which is true. *See* Dzirasa Decl. ¶¶ 28–31 (“We have limited funds and staffing resource, and therefore cannot create additional positions to cover for employees who refuse to provide certain services.”); Matz Decl. ¶¶ 9–16 (“If any employee on a medic unit decided, at the scene of a call, that they could not perform their job for religious, moral, or ‘other’ reasons, the results could be

³¹ The Court should also reject HHS’s conclusory severance argument. HHS’s failure to suggest which parts of the Rule should be severed makes it impossible to determine whether the agency “would have adopted the severed portion on its own.” *New Jersey v. EPA*, 517 F.3d 574, 584 (D.C. Cir. 2008). Although the Rule declares that any invalid provision should be severed, 84 Fed. Reg. at 23,272, “[w]hether the offending portion of a regulation is severable depends upon the intent of the agency *and* upon whether the remainder of the regulation could function sensibly without the stricken provision.” *MD/DC/DE Broadcasters Ass’n v. F.C.C.*, 236 F.3d 13, 22 (D.C. Cir. 2001). Here, the Rule’s provisions are so intertwined and the provisions the City challenges are so central to its operation that the entire Rule must be vacated. At a minimum, if the Court vacates parts of the Rule but believes others may be severable, the City requests the opportunity to brief the issue after receiving the benefit of the Court’s judgment regarding which parts of the Rule are invalid.

catastrophic.”).

In keeping with its failure to acknowledge the adverse effects of the Rule on healthcare providers and patients, HHS characterizes the harm the City faces if the Rule takes effect as “ordinary compliance costs.” Mot. 54 (quoting *Freedom Holdings, Inc. v. Spitzer*, 408 F.3d 112, 115 (2d Cir. 2005)). HHS likens the City’s bind—“(1) attempt to comply with the Rule and allow its employees to refuse to provide care, resulting in the unethical practice of medicine and endangering the lives of patients and residents, or (2) fail to comply and disproportionately risk losing crucial federal funding,” PI Motion 37—to a *cigarette manufacturer’s* claimed harm of *lost profits*, and says there is “no reason why [the City’s] case should be treated any differently.” Mot. 54 (citing *Freedom Holdings*, 408 F.3d at 115). If logic does not cause the Court to reject this analogy, the cases the City cites in it PI Motion at 37, 41, 44, confirm that both the economic and non-economic harms the City articulates are routinely found to justify a preliminary injunction, including where, as here, the injunction seeks to delay implementation of a challenged regulation.³²

If the Court grants an injunction pending final judgment, the only way to preserve the status quo and afford complete relief to the City is to grant a nationwide injunction. As courts have recognized, “[w]hen a reviewing court determines that agency regulations are unlawful, the ordinary result is that the rules are vacated—not that their application to the individual petitioners is proscribed.” (internal quotations and alterations omitted. *Nat’l Min. Ass’n v. U.S. Army Corps of Engineers*, 145 F.3d 1399, 1406 (D.C. Cir. 1998) (granting nationwide injunction). A nationwide injunction is particularly appropriate where, as here, the City itself will feel the effects

³² HHS’s citation at Mot. 55 of *Maryland v. King*, 133 S. Ct. 1, 3 (2012) for the proposition that the government’s harms outweigh the City’s is similarly inapposite. That case involved *statute* enacted by citizens of Maryland, not a regulation enacted by an administrative agency. Moreover, the statute was already in force – thus the “status quo” was preserved by allowing Maryland to continue enforcing it. That is not the case here.

of the Rule nationwide. The City is the health insurer to retired City employees, who reside in all fifty States and also may have need of healthcare, including emergency care, when they travel. *See* Decl. of Ray Gulhar ¶ 2; PI Motion at 9, 46. Thus, a nationwide injunction is necessary to afford full relief. *Va. Soc’y for Human Life, Inc. v. Fed. Election Comm’n*, 263 F.3d 379, 393 (4th Cir. 2001) (“Nationwide injunctions are appropriate if necessary to afford relief to the prevailing party.”) *overruled on other grounds in The Real Truth About Abortion, Inc. v. Fed. Election Comm’n*, 681 F.3d 544 (4th Cir. 2012); *S.C. Coastal Conservation League v. Pruitt*, 318 F. Supp. 3d 959, 969 (D.S.C. 2018) (granting national injunction where rule “will affect downstream waters not just in South Caroline or even within the Fourth Circuit but throughout the United States and members of plaintiff will be affected across the United States).

CONCLUSION

For the reasons set forth above, the Court should issue a judgment before November 22, 2019, declaring the Rule unlawful and vacating it. Alternatively, the Court should enter a nationwide preliminary injunction before November 22, 2019, and issue a final judgment vacating the Rule at an appropriate time after that date.

DATED: September 19, 2019

Respectfully submitted

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CERTIFICATE OF SERVICE

I hereby certify that on September 19, 2019 the foregoing document was electronically filed with the Clerk of the Court using the CM/ECF system and all counsel of record will receive an electronic copy via the Court's CM/ECF system.

/s/ Elisha B. Barron

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