19-4254(L), 20-31, 20-32, 20-41

United States Court of Appeals
for the Second Circuit

STATE OF NEW YORK, CITY OF NEW YORK, STATE OF COLORADO, STATE OF CONNECTICUT, STATE OF DELAWARE, DISTRICT OF COLUMBIA, STATE OF HAWAII, STATE OF ILLINOIS, STATE OF MARYLAND, COMMONWEALTH OF MASSACHUSETTS, STATE OF MICHIGAN, STATE OF MINNESOTA, STATE OF NEVADA, STATE OF NEW JERSEY, STATE OF NEW MEXICO, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, STATE OF RHODE ISLAND, STATE OF VERMONT, COMMONWEALTH OF VIRGINIA, STATE OF WISCONSIN, CITY OF CHICAGO, COOK COUNTY, ILLINOIS,.,

Plaintiffs-Appellees,

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, INC., NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION, PUBLIC HEALTH SOLUTIONS, INC.,

Consolidated-Plaintiffs-Appellees,

On Appeal from the United States District Court for the Southern District of New York, No. 1:19-cv-04676-PAE (consolidated with 1:19-cv-05433-PAE; 1:19-cv-05435-PAE)

INTERVENOR-DEFENDANTS-APPELLANTS' OPENING BRIEF

(*Caption continued on and counsel listed on inside cover*)

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES OF AMERICA,

Defendants-Appellants,

DR. REGINA FROST AND CHRISTIAN MEDICAL AND DENTAL ASSOCIATIONS,

Intervenors-Defendants-Appellants,

ROGER T. SEVERINO, IN HIS OFFICIAL CAPACITY AS DIRECTOR, OFFICE FOR CIVIL RIGHTS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND OFFICE FOR CIVIL RIGHTS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Consolidated-Defendants-Appellants.

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1 and to enable Judges of the Court to evaluate possible disqualification or recusal, the undersigned counsel for Intervenors-Defendants-Appellants Dr. Regina Frost and Christian Medical and Dental Associations (private non-governmental parties) certify that Intervenors-Defendants-Appellants have no corporate parents, affiliates, and/or subsidiaries, which are publicly held.

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PRELIMINARY STATEMENT

As our nation grapples with its deadliest pandemic since the Spanish Flu, we are constantly reminded of the critical role played every day by doctors, nurses, EMTs, and other health care professionals. They work tirelessly to protect the lives, health, and well-being of patients everywhere.

Thousands of these medical professionals are inspired and motivated to serve others by their religious faith. To ensure that these caregivers are not forced to choose between the dictates of their conscience and the demands of their employers, Congress has acted again and again to prohibit discrimination against health care professionals on the basis of their beliefs. Yet for decades, many of these prohibitions on discrimination went largely unenforced—and the protections they afforded unrealized.

Finally, in 2008, the Department of Health and Human Services set out to promulgate a rule that would ensure these laws are respected and enforced. HHS proposed and adopted a regulation requiring HHS funding recipients to certify compliance with the freedom-of-conscience protections enacted by Congress in the conscience statutes; charged HHS's Office of Civil Rights with investigating complaints of violations of those statutes; and defined terms used in those statutes. Thousands of commenters strongly supported the rule—and reported that in its absence health care professionals suffered discrimination because of their beliefs.

Only a few months after the 2008 rule came into effect, however, a new administration proposed to rescind it—remarking that it did not accord with the administration's priorities. But hundreds of thousands of commenters opposed the rescission—explaining that before the 2008 rule, health care professionals were regularly subject to discrimination in violation of the conscience statutes, and that without the rule, many health care professionals would be forced to give up their profession rather than violate their conscience.

Even though commenters opposed rescinding the rule by nearly 2 to 1, the administration pressed forward. In 2011, it promulgated a final rule that eliminated virtually the entire 2008 rule—including its certification requirement and definitions of statutory terms. All that remained was a provision stating that complaints should be directed to OCR.

Unsurprisingly, health care professionals continued to be coerced into performing procedures to which they objected as a matter of conscience, and faced discrimination if they refused to accede. States and local governments passed laws that infringed on health care professionals' freedom of conscience and religion. Some organizations even sued to force health care professionals to perform procedures that violated their conscience—in direct contravention of the conscience statutes.

In 2018, recognizing that discrimination in violation of the conscience statutes remained at least as much of a problem as it had been in 2008, HHS set out to revive the robust protections in the 2008 rule. In 2019, HHS promulgated the final rule at issue here—the Conscience Rule—which re-implemented the 2008 rule's certification requirements, and again defined many statutory terms.

Plaintiffs challenge the Rule on a variety of legal grounds. But at the core of this case is a political dispute, not a legal one. Plaintiffs prefer the approach taken by the 2011 rule. As a policy matter, they would prefer that HHS not focus on enforcing the conscience statutes, even though they have agreed to the statutes' terms for decades in exchange for accepting federal funds. But Plaintiffs' disagreements with the Conscience Rule provide no basis for invalidating it.

The Rule was promulgated pursuant to statutory authority and does not violate the Constitution or any other law. The district court should have rejected Plaintiffs' challenge to the Rule, and this Court should reverse and render judgment for appellants.

STATEMENT OF JURISDICTION

The district court entered summary judgment in favor of Plaintiffs-Appellees on November 6, 2019. SA 148-59.[1] Intervenors-Defendants-Appellants Dr. Regina Frost and CMDA timely filed their notice of appeal on December 18, 2019 in Nos. 19-cv-04676-PAE, 19-cv-05433-PAE, and 19-cv-05435. JA 2760. The government Defendants-Appellants timely filed their notices of appeal on January 3, 2020 in Nos. 19-cv-04676-PAE, 19-cv-05433-PAE, and 19-cv-05435. JA 2764, 2767, 2770. The district court had jurisdiction under 28 U.S.C. §§ 1331 and 2201(a), as well as the judicial review provisions of the Administrative Procedure Act, 5 U.S.C. § 702. This Court has jurisdiction under 28 U.S.C. § 1291.

ISSUES PRESENTED FOR REVIEW

1. Did the district court reversibly err in granting summary judgment to plaintiffs and vacating the Conscience Rule where (a) HHS had statutory authority to promulgate the Rule, and (b) the Rule is consistent with the Administrative Procedure Act?

2. Did the district court reversibly err in granting summary judgment to Plaintiffs and vacating the Conscience Rule where the Rule does not even implicate, much less violate, the Spending Clause?

[1] "SA" refers to the Special Appendix and "JA" refers to the Joint Appendix, both filed concurrently with the Government's Brief.

STATEMENT OF THE CASE

I. Factual Background

A. The Conscience Statutes Protect Health Care Professionals, Like CMDA's Members, Who Are Inspired By Their Faith To Serve Others.

Since its founding in 1931, CMDA has educated and equipped its members—including Dr. Frost—to glorify God by serving with professional excellence as witnesses of Christ's love and compassion to all people. JA 1488 ¶ 6.

CMDA affirms that it is the duty of Christian health care professionals to treat *every* patient with compassion—even if doing so might put the professional's own health or safety at risk—and that this duty extends to all, "regardless of sexual orientation, gender identification, or family makeup." JA 1489 ¶¶ 11-12. CMDA members have carried out this mission by caring for tens of thousands of patients during civil conflict in Somalia, genocide in Rwanda, civil war in Sudan, and the ongoing coronavirus crisis. JA 1487 ¶ 4; Sheri Fink, *Treating Coronavirus in a Central Park 'Hot Zone'*, N.Y. TIMES (Apr. 15, 2020), https://www.nytimes.com/2020/04/15/nyregion/coronavirus-central-park-hospital-tent.html (reporting on the Central Park field hospital established by Samaritan's Purse, an organization affiliated with CMDA).

CMDA embraces treating every patient with compassion. JA 1489-90 ¶¶ 11, 14-16. But performing certain *procedures*—including abortion and physician-assisted suicide—is incompatible with its members' sincere beliefs. JA 1490-91

¶¶ 17, 19. CMDA believes that physicians should not be forced to violate their conscience, nor should they "hinder the continuity of care, even when they object to a particular procedure." JA 1490 ¶ 13.

To ensure its members can practice medicine and exercise medical judgment without violating their personal beliefs and values, CMDA has long advocated for conscience protections for health care professionals. JA 1489 ¶ 9. Again and again, Congress has responded by ensuring that entities receiving federal funds cannot discriminate against health care professionals when they exercise their conscience rights. For example:

- **The Church Amendments** prohibit discrimination against those who hold religious beliefs or moral convictions about certain health care procedures, including abortion and sterilization. 42 U.S.C. § 300a-7(c)(1), (d).
- **The Coats-Snowe Amendment** prohibits discrimination against any health care entity that refuses to facilitate abortions or train its employees to perform abortions. 42 U.S.C. §§ 238n(a), (c)(2).
- **The Weldon Amendment** strips federal funds from any government entity that discriminates on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions. Pub. L. No. 115-245 § 507(d)(1), 132 Stat. 2981, 3118 (2018).
- **The Patient Protection and Affordable Care Act (ACA)** prohibits discrimination against health care professionals who object to providing or assisting in procedures such as physician-assisted suicide, and who are unwilling to provide, pay for, cover, or make referrals for abortions. 42 U.S.C. §§ 18113, 18023(a)(1), (b)(1)(A), (b)(4).

As the Conscience Rule explains, other appropriations bills and statutes similarly prohibit federally funded entities from violating the conscience rights of health care

professionals who have religious objections to abortion, sterilization, or physician-assisted suicide. *See Protecting Statutory Conscience Rights in Health Care; Delegations of Authority*, 84 Fed. Reg. 23,170, 23,172-74 (May 21, 2019).

B. HHS Promulgated The 2008 Rule To Enforce The Conscience Protections And Clarify Their Scope.

Before 2008, the conscience statutes essentially went unenforced. Commentators across the political spectrum observed that while "the Federal Government has the power to withdraw funding should a recipient violate the conditions on the funding [in the conscience statutes], the government has virtually never done so, or even threatened to do so." *See, e.g.*, Leora Eisenstadt, *Separation of Church and Hospital: Strategies to Protect Pro-Choice Physicians in Religiously Affiliated Hospitals*, 15 YALE J.L. & FEMINISM 135, 159 n.112 (2003).[2]

In 2008, then-HHS Secretary Michael Leavitt directed the agency to submit notice of a proposed rule aimed at enforcing the conscience statues, based on evidence that some medical organizations were disregarding the conscience statutes and forcing their members "to choose between their capacity to practice in good

[2] *See also* Robin Fretwell Wilson, *Empowering Private Protection of Conscience*, 9 AVE MARIA L. REV. 101, 102-03 (2010) ("Until the [2008 rule], the government provided no way for persons to file a complaint about possible violations."); *Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws*, 76 Fed. Reg. 9968, 9972 (Feb. 23, 2011) (before 2008, "there was no clear mechanism for a health care provider who believed his or her rights were violated to seek enforcement of those rights").

standing and their right of conscience." *Ensuring that Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law*, 73 Fed. Reg. 50,274, 50,276 (Aug. 26, 2008).

In response to the 2008 notice of proposed rulemaking, "numerous [c]ommenters reported what they believed to be individual instances of violation of conscience, including health care providers suffering loss of employment, adverse actions during medical training, and discrimination in residency placement, among other consequences, due to their assertion of their conscience rights." *Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law*, 73 Fed. Reg. 78,072, 78,078 (Dec. 19, 2008). "Some [c]ommenters also reported pressure to perform certain procedures from State authorities, professional organizations, or employers that appeared to the [c]ommenters to be inconsistent with federal conscience protections." *Id.* Many commentators "supported the [proposed] regulation as a necessary and useful mechanism to support statutory protection." *Id.*

Based on the evidence that health care professionals faced discrimination on the basis of their religious or moral beliefs—and that the conscience statutes, on their own, failed to stop this illegal discrimination—HHS adopted the final rule (the "2008 Rule"). *Id.* at 78,073 ("As noted in the preamble to the proposed rule, the Department is concerned about the development of an environment in sectors of the

health care field that is intolerant of individual objections to abortion or other individual religious beliefs or moral convictions."); *id.* at 78,078 ("The Comments received in Response to the proposed rule support the Department position that the regulation is necessary to implement the statutes.").

To provide an enforcement mechanism for the conscience statutes, the 2008 Rule mandated that HHS's Office for Civil Rights (OCR) would "receive complaints of discrimination and coercion based on the health care conscience protection statutes and this regulation," investigate those complaints, and coordinate appropriate remedial action—including withholding funds—if it discovered violations. *Id.* at 78,074. The 2008 Rule required HHS funding recipients to submit "written certification[s]" stating "that they will comply with all three [conscience] statutes." *Id.* at 78,072. And the Rule defined certain terms used in the conscience statutes to "clarif[y] the scope of protections" set forth in the statutes and "ensure [the statutes'] proper enforcement." *Id.* at 78,074.

C. A New Administration Rescinded The 2008 Rule, Despite Overwhelming Support For It.

Just a month after the 2008 Rule went into effect, the incoming administration proposed to rescind it. *Rescission of the Regulation Entitled "Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law"; Proposal*, 74 Fed. Reg. 10,207 (Mar. 10, 2009). The administration did not suggest that the

concerns that had motivated the rule were invalid or had dissipated, but instead suggested that it did not view the rule as aligned with the administration's priorities: "It is important that the Department have the opportunity to review this regulation to ensure its consistency with current Administration policy." *Id.* at 10,209.

Although the new administration remained committed to its policy decision to rescind the 2008 Rule, its own rulemaking process revealed substantial evidence *supporting* the regulation—and making clear that it addressed a real and pressing problem. The administration reported that in response to its request for comment on its rescission proposal, commenters submitted almost 187,000 comments opposing rescission and supporting the 2008 Rule—nearly double the number of comments supporting the administration's approach. *See* 76 Fed. Reg. at 9971.[3]

The comments supporting the 2008 Rule offered direct evidence of the regulation's importance in amplifying and clarifying the conscience statutes' protections. Many commentators "related anecdotes of hospitals and other health care entities failing to respect the conscience rights of health care providers" and

[3] The true number of comments supporting the 2008 Rule may have been even higher—some organizations reported that at least 340,000 commenters supported the prior regulation and opposed rescission. *See* Tom McFreely, *Conscience Rights and Obama*, National Catholic Register (July 9, 2009), https://www.ncregister.com/blog/tom-mcfeely/conscience_rights_and_obama; Tim Waggoner, *340,000 Support Conscience Rights of Healthcare Workers*, LifeSite News (May 1, 2009), https://www.lifesitenews.com/news/340000-support-conscience-rights-of-healthcare-workers.

"opined that if the 2008 Final Rule was rescinded in its entirety, health care entities receiving federal funding would not honor the rights provided health care providers under the Federal health care provider conscience protection statutes." *Id.* at 9972.

Despite the overwhelming opposition to rescission, the administration pressed forward. It largely dismissed the commenters' concerns, asserting that HHS could address any lack of respect for the conscience statutes with "education and outreach," rather than through regulation. *Id.* Its final rule (the "2011 Rule") retained only a three-sentence provision giving OCR responsibility for handling complaints under the conscience statutes—but not including any definitions to provide guidance about the scope of those statutes, or any requirement that employers affirmatively certify compliance with the statutes. *Id.* at 9976-77.

Soon after HHS promulgated the 2011 Rule, dozens of states and municipalities enacted laws infringing on the rights protected by the conscience statutes. 84 Fed. Reg. at 23,176-77. This, in turn, prompted "an increase in lawsuits against State and local laws that plaintiffs allege[d] violate[d] conscience or unlawfully discriminate[d]." *Id.* at 23,176.

Courts held, however, that the conscience statutes "do not contain, or imply, a private right of action to seek relief." *Id.* at 23,178. So, for example, a nurse who was denied a position because she objected to prescribing abortifacients could not

seek relief from that discrimination under the Church Amendment. *See id.* (citing *Hellwege v. Tampa Family Health Ctrs.*, 103 F. Supp. 3d 1303 (M.D. Fla. 2015)).[4]

D. HHS Proposed The Conscience Rule To Reinvigorate Enforcement Of The Conscience Statutes And Again Clarify Their Scope.

Recognizing that "adequate governmental enforcement mechanisms are critical" to protect conscience rights, 84 Fed. Reg. at 23,178, HHS proposed a new rule in 2018 "to enhance the awareness and enforcement of Federal health care conscience and associated anti-discrimination laws, to further conscience and religious freedom, and to protect the rights of individuals and entities to abstain from certain activities related to health care services without discrimination or retaliation." *Protecting Statutory Conscience Rights in Health Care; Delegations of Authority*, 83 Fed. Reg. 3880, 3881 (Jan. 26, 2018).

The new proposed rule largely returned to the structure of the 2008 Rule, including its certification requirement and its definition of statutory terms. *Id.* at

[4] The Conscience Rule at issue here cited many other lawsuits implicating violations of the conscience statutes, including *Roman Catholic Diocese of Albany v. Vullo*, No. 02070-16 (N.Y. Albany County S. Ct. May 4, 2016); *Means v. U.S. Conf. of Catholic Bishops*, 2015 WL 3970046 (W.D. Mich. June 30, 2015); *ACLU v. Trinity Health Corp.*, 178 F. Supp. 3d 614 (E.D. Mich. 2016); *Minton v. Dignity Health*, No. 17-558259 (Cal. Super. Ct. Apr. 19, 2017); *Chamorro v. Dignity Health*, No. 15-549626 (Cal. Super. Ct. Dec. 28, 2015); *Mendoza v. Martell*, No. 2016–6–160 (Ill. 17th Jud. Cir. June 8, 2016); *Cenzon-DeCarlo v. Mt. Sinai Hosp.*, 626 F.3d 695, 696 (2d Cir. 2010); Compl., *Danquah v. University of Medicine and Dentistry of New Jersey*, No. 2:11-cv-6377 (D.N.J. Oct. 31, 2011) (alleging that public hospital's policy required nurses to assist in abortions). *See* 84 Fed. Reg. at 23,176-79 & n.27.

3891 ("This proposed rule would generally reinstate the structure of the 2008 Rule, supplemented with further definition of Federal health care conscience and associated anti-discrimination laws and robust notice and enforcement provisions.").

1. The Conscience Rule Was Supported By Evidence That A New Rule Was Necessary To Protect Health Care Professionals.

While the prior rulemakings provided ample support on their own for HHS's decision to promulgate a rule that—like the 2008 Rule before it—explained the scope of the conscience statutes and enforced their prohibitions and protections, HHS identified abundant other evidence supporting its new regulation.

One important piece of evidence was offered by CMDA, which submitted comments in support of the revised rule that cited a 2009 survey of 2,865 members of faith-based medical associations conducted by the Christian Medical Association. *See* 84 Fed. Reg. at 23,175. This survey found that "39% [of respondents] reported having faced pressure or discrimination from administrators or faculty based on their moral, ethical, or religious beliefs." *Id.*

"Additionally," the survey found, "32% of the survey respondents reported having been pressured to refer a patient for a procedure to which they had moral, ethical, or religious objections." *Id*. And "91% of respondents reported that they 'would rather stop practicing medicine altogether than be forced to violate [their] conscience.'" *Id*. The survey further indicated that conscience issues affect medical students' decisions about their careers—with 20% reporting "that they would not

pursue a career in obstetrics or gynecology because of perceived discrimination and coercion in that specialty against their beliefs." *Id.*

In a follow-up survey conducted two years later (and also submitted in connection with the 2018-19 rulemaking), 82% of respondents thought "it was either 'very' or 'somewhat' likely that they personally would limit the scope of their practice of medicine if conscience rules were not in place." *Id.* at 23,181 n.48.

These surveys helped "demonstrate" to HHS "that a lack of conscience protections diminishes the availability of qualified health care providers." *Id.* at 23,246. HHS expressed concerns that some "currently practicing health providers" who are leaving the profession "are motivated by coercion or discrimination based on providers' religious beliefs or moral convictions." *Id.* at 23,247. CMDA member Dr. Frost, for example, has learned of physicians who have been terminated or discriminated against because of their religious beliefs. JA 1499 ¶ 13.

Likewise, a 2019 survey of CMDA members confirmed that nearly a quarter of respondents had been personally discriminated against in their profession due to their religious beliefs, another 42% had seen or known someone suffering such discrimination, more than a third had been pressured to participate in conscience-violating procedures, and more than 75% believed that religious discrimination against health care professionals was increasing. JA 1506 ¶¶ 15-17.

HHS also cited evidence produced during its previous two rulemakings, along with evidence of subsequent developments, including:

- Thousands of comments attesting to the prevalence of discrimination and coercion in the health care profession;

- Litigation demonstrating a lack of understanding about the conscience statutes' protections, including suits alleging that health care professionals should be forced to perform abortions and sterilizations over their objections; and

- A medical journal article and ethics statement suggesting that the health care profession should not accommodate medical professionals who oppose abortion as a matter of conscience.

See 84 Fed. Reg. at 23,175-79; *see also id.* at 23,228-29. As HHS explained, this evidence demonstrated that the conscience statutes were still being ignored, that stronger enforcement mechanisms were necessary, and that clear definitions setting out the meaning of the statutes' terms and the scope of their coverage were needed. *Id.* at 23,179-80.

2. The Conscience Rule's Provisions Reinforced And Clarified The Conscience Statutes.

Based on all of this evidence, HHS "concluded that there is a significant need to amend the 2011 Rule to ensure knowledge of, compliance with, and enforcement of Federal conscience and anti-discrimination laws." *Id.* at 23,170. HHS promulgated the Conscience Rule at issue in this appeal, recognizing that "[t]he freedoms of conscience and of religious exercise are foundational rights protected by the Constitution and numerous Federal statutes." *Id.* The Conscience Rule makes

clear that OCR "has a singular and critical responsibility . . . to conduct compliance reviews, to investigate alleged violations, and to vigorously enforce those laws." *Id.* at 23,178.

The Rule's requirements reflect existing federal statutes and regulations, often in "laws [that] have existed for decades." *Id.* at 23,222. The Rule reinstates the enforcement provisions of the 2008 Final Rule and defines several key terms, including "assist in the performance," "discrimination," and "health care entity." *See* 24 C.F.R. § 88.2 (2019). And it encourages recipients of federal funds to notify individuals and entities protected under federal conscience and anti-discrimination laws—such as employees, job applicants, and medical students—of their conscience rights. *See id.* § 88.5.

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

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

3. HHS Carefully Considered And Responded To Comments.

In promulgating the Conscience Rule, HHS considered many of the same concerns Plaintiffs raise here about the Rule's potential costs and impact on patient care. The Rule responds to these concerns and, where HHS deemed appropriate, made changes to address them. *See id.* at 23,180-23,226.

Access to care. Responding to concerns that the Rule would decrease access to health care, HHS noted that the Rule simply implemented conscience statutes that already existed. *Id.* at 23,180 (citing responses to similar concerns made during the 2008 rulemaking). These statutes "represent Congress's considered judgment that these rights are worth protecting *even if* they impact overall or individual access to a particular service, such as abortion." *Id.* at 23,182 (emphasis added). But HHS

also pointed to studies "specifically f[inding] that there is insufficient evidence to conclude that conscience protections have negative effects on access to care." *Id.* at 23,180, 23,253-54.

HHS also looked to "academic literature on the benefits of conscience protections in health care," and concluded that it "supports the proposition that prohibiting the exercise of conscience rights in medicine *decreases* the quality of care that patients receive." *Id.* at 23,246 (emphasis added). And HHS found additional support in the thousands of comments it received in 2009 asserting that doctors would leave (or not enter the profession at all) if HHS failed to protect conscience rights. *Id.* at 23,175-76.

HHS concluded that the new Conscience Rule would "remove barriers to entry into the health care professions," and found it "reasonable to assume that the rule may … *increase*, not decrease, access to care." *Id.* at 23,180 (emphasis added); *see also id.* at 23,210 (concluding that "conscience protection ensures diversity in the health care industry and maximizes the number of health care professionals in the United States, which helps all patients").

Similarly, HHS found that rigorous enforcement of "Federal conscience and anti-discrimination laws" is necessary to "prevent health care providers from being unlawfully driven out of business." *Id.* at 23,253. Without the Conscience Rule, HHS explained, "[i]nstead of a decrease in access to a particular *procedure* from a

particular doctor or provider, the residents of a rural area would face the potential of receiving no health care *at all* from that doctor or provider because such providers may leave the practice if unable to practice medicine according to their religious beliefs or moral convictions." *Id.* at 23,254 (emphases added).

Notification of Conscience-Based Objections. Some commenters suggested that employers should be allowed to ask employees (and prospective hires) about their religious beliefs, but HHS rejected that suggestion, reasoning that "it is not an acceptable practice under Federal conscience and antidiscrimination laws for covered entities to deem persons with religious or moral objections to covered practices, such as abortion, to be disqualified for certain job positions on that basis." *Id.* at 23,191.

Still, to accommodate these concerns, HHS modified the Rule so that "employers may require a protected employee to inform them of objections . . . to the extent there is a reasonable likelihood that [they] may be asked in good faith to" engage in the objected-to conduct. *Id.*

HHS added a provision further clarifying that "[a]n employer may similarly require an employee to notify them in a timely manner of an actual conscientious objection that the employee has to a specific act, in the day-to-day course of work, that the employee would otherwise be expected to perform." *Id.* at 23,201. HHS

determined that these additions "str[uck] the right balance," furthering the interests of employers, patients, and health care professionals. *Id.* at 23,192.

Accommodations. In response to concerns about whether the Rule would allow employers to offer accommodations to conscientious objectors, HHS modified the Rule's definition of "discrimination" "to make clear that employers can use, and are encouraged to pursue, accommodation procedures with protected employees." *Id.* at 23,201. HHS added that it "will take into account an entity's adoption and implementation of policies to accommodate objecting persons in making determinations of discrimination." *Id.* at 23,191.

II. Procedural Background

Notwithstanding HHS's efforts to address the concerns raised during the notice-and-comment process, a collection of States, municipalities, and non-profit organizations filed three parallel actions against HHS seeking to invalidate the Rule. JA 131, 211, 264. Plaintiffs alleged that the Rule exceeds HHS's statutory authority; violates the Administrative Procedure Act; and offends the Spending Clause, the Establishment Clause, and the separation of powers.

Dr. Frost and CMDA moved to intervene in the action filed by the state and municipality plaintiffs, Case No. 1:19-cv-04676. JA 28-29. Before ruling on the motion to intervene, the court consolidated all three cases. JA 1241. The court then granted Dr. Frost's and CMDA's motion, explaining that they "have asserted a

cognizable interest in this action" and permitting them to intervene "will assist the Court in resolving issues before it." JA 1299, 1304.

Both sides moved for summary judgment. After a hearing, the district court (Engelmayer, J.) granted summary judgment to Plaintiffs, ruling for them on most of their challenges. *See* SA 1-147; *New York v. United States Dep't of Health & Human Servs.*, 414 F. Supp. 3d 475 (S.D.N.Y. 2019).

In particular, the court held that Rule was "not in accordance with law" under the APA because (i) it did not incorporate the "undue hardship" framework of Title VII of the Civil Rights Act, SA 71-73, and (ii) did not include an "emergency" exception, which the court held was required by the Emergency Medical Treatment and Labor Act ("EMTALA"), SA 74-78.

The court further held that the Rule was arbitrary and capricious under the APA because, according to the court, there had not been a "significant increase in complaints" under the conscience statutes, and so HHS's "justifications" for the Rule were contrary to the evidence about the number of complaints. SA 80-89. The court also held that the Rule violated the APA for the additional reason that HHS failed to supply a sufficient explanation for its policy change from the 2011 Rule to the Conscience Rule because, according to the court, HHS in 2011 made a "factual finding" that regulations that define terms in the conscience statutes cause "confusion" about those statutes, thereby imposing on HHS a heightened obligation

to explain its "contrary" finding in 2019 that regulations defining statutory terms do not cause "confusion." SA 91-94.

The court determined that the Rule violated the APA for the additional reasons that, in the court's view:

- HHS did not justify its departure from another purported 2011 "factual finding" that rules which enforce and implement conscience statutes, like the Conscience Rule, "limit access to care," SA 94-98;
- "Serious reliance interests" had developed among regulated entities on the 2011 Rule's absence of statutory definitions to conclude that the conscience statutes did not protect all or some of their employees, SA 98-103;
- HHS did not "adequately" consider the Rule's interactions with EMTALA and Title VII, and thus failed "entirely" to consider that aspect of the problem before the agency, SA 103-09; and
- The Rule was not a "logical outgrowth" of the notice of proposed rulemaking, because it did not incorporate Title VII's "undue hardship" framework, SA 109-15.

The district court further ruled that Section 88.7(i)(3)(iv) of the Rule violates the Spending Clause, even though the underlying conscience statutes do not, SA 117-34. The court rejected Plaintiffs' Establishment Clause challenge, however, explaining that "the Rule equally accommodates all conscience-based objections," and thus "does not elevate religious objectors over others." SA 136.

The court concluded that the appropriate remedy for the APA violations it found was to vacate the Rule in its entirety, and directed the clerk to enter judgment vacating the Rule. SA 141-59.

STANDARD OF REVIEW

This Court reviews the district court's legal conclusions *de novo*, including its conclusions regarding the scope of a statute and the constitutionality of a regulation. *See New York State Rifle & Pistol Ass'n, Inc. v. Cuomo*, 804 F.3d 242, 252 (2d Cir. 2015).

On appeal from a grant of summary judgment involving an APA claim, this Court "review[s] the administrative record *de novo* without according deference to the decision of the district court." *Karpova v. Snow*, 497 F.3d 262, 267 (2d Cir. 2007). Under the APA, an agency's decision must be upheld unless arbitrary, capricious, an abuse of discretion, or otherwise contrary to law. *See* 5 U.S.C. § 706(2)(A). Under this deferential standard, an agency's decision is presumed valid, and the only question is whether it "was based on a consideration of the relevant factors and whether there has been a clear error of judgment." *Citizens to Pres. Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971).

An agency's decision is arbitrary and capricious only where the agency "has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency[,]" or its decision "is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Motor Vehicle Mfrs. Ass'n, Inc. v. State Farm Mut. Auto. Ins.*

Co., 463 U.S. 29, 43 (1983). The Court may not "substitute its judgment for that of the agency." *Id.*

SUMMARY OF THE ARGUMENT

The Rule—like the conscience statutes it interprets, clarifies, and enforces—simply requires that employers not discriminate against health care professionals for exercising their conscience rights. Plaintiffs may not like the policy choices embodied by the conscience statutes—or the administrative decision to enforce them. But those are policy disagreements—not legal ones—and cannot justify invalidating the Rule under either the APA or the Constitution.

I. The Rule easily passes muster under the APA. The district court held that the Rule is contrary to law (and violates the APA) because it "conflicts" with Title VII by not incorporating Title VII's "undue hardship" framework. But there is no conflict. The undue hardship framework is not part of any statute the Rule implements. Because the conscience statutes do not incorporate Title VII or its framework, the Rule could not either. Nor is there any conflict with EMTALA. Hospitals can (and do) ably provide emergency services without forcing health care professionals to violate their conscience rights.

The resulting rule was thus consistent with existing law—and the agency's decision-making process was anything *but* arbitrary and capricious. HHS reviewed voluminous evidence—compiled over the course of three rulemakings—

demonstrating the need to enforce the conscience statutes' protections and clarify their scope. HHS thoughtfully and comprehensively responded to comments and concerns—explaining the agency's analysis and rationale. And HHS offered ample, record-based justifications for the Rule—contrary to the district court's erroneous conclusion that the Rule was based on faulty evidence.

Although the district court thought that HHS inadequately explained its change from 2011 (and its return to the 2008 approach), HHS more than satisfied the relevant requirement "that it display awareness that it *is* changing position" and "show that there are good reasons for the new policy." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009). Nothing more was needed.

The district court also faulted HHS for not "adequately" considering important aspects of the problem before it. But HHS *did* adequately consider the problem under the proper legal standards, which make clear that deferential arbitrary-and-capricious review cannot devolve into second-guessing an agency's policy choices. *Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2570 (2019) (rejecting an arbitrary-and-capricious challenge, because "the choice between reasonable policy alternatives in the face of uncertainty was the [agency]'s to make"); *FERC. v. Elec. Power Supply Ass'n* ("*EPSA*"), 136 S. Ct. 760, 782 (2016) ("[W]e may not substitute our own judgment for that of the [agency].").

Nor did the agency fail to give proper notice of the proposed rulemaking. The district court determined that the final Conscience Rule was not a "logical outgrowth" of the proposed rule because the Rule did not mention Title VII's undue hardship framework. But that is because the conscience statutes are not governed by Title VII and do not incorporate that framework—so there was no reason for the notice of proposed rulemaking to expressly state that the Rule would not be using that framework.

II. The Rule does not violate the Spending Clause. That constitutional provision cabins Congress's ability to place conditions on funds given to the States—but all parties agree that the funding restrictions in the conscience statutes are constitutionally valid. And contrary to the district court's conclusion, the Rule does *not* impose new funding conditions beyond those already in the statutes. The grant of summary judgment should be reversed (and rendered for appellants) for that reason, too.

ARGUMENT

I. The Conscience Rule Easily Passes Muster Under Deferential APA Review.

As the Government's brief explains, HHS has ample statutory authority to promulgate rules, such as the Conscience Rule, interpreting *all* of the conscience statutes. Gov. Br. 20-37. The district court erred in holding that HHS lacked authority to promulgate those parts of the Rule interpreting the Church, Coats-

Snowe, and Weldon Amendments. *Id.* at 26-28; *see also id.* at 28-37 (explaining that the Rule's definitions align with the ordinary meaning of the statutory terms). And it erred in holding that the Rule's enforcement provisions were not authorized by statute. *Id.* at 20-26.[5]

The district court compounded those errors by accepting Plaintiffs' scattershot alternative arguments that the Rule violates the APA in other ways. The Rule, like the conscience statues it implements, is perfectly consistent with other statutes, including Title VII and EMTALA. It is far from arbitrary and capricious, and it was promulgated with ample notice.

A. The Conscience Rule Is Consistent With Other Law.

1. The Conscience Rule Does Not Conflict With Title VII.

As the district court correctly recognized, Title VII applies an "undue hardship" framework, under which an employer may defend against a religious discrimination claim by arguing that "he is unable to *reasonably accommodate* to an employee's or prospective employee's religious observance or practice *without undue hardship* on the conduct of the employer's business." 42 U.S.C. § 2000e(j) (emphases added).

[5] The district court's separation-of-powers holding merely recapitulates its holding that one of the Rule's enforcement provisions was not statutorily authorized. SA 115-16; *see id.* at 64-69. If HHS has statutory authority for the enforcement provision, *see* Gov. Br. 23-24, then there is no separation-of-powers violation, either.

But Congress did not use this framework in the conscience statutes. Instead, Congress flatly prohibited "discrimination" based on an employee's objection to abortion or other religious beliefs, without *any* exception for undue hardship. *See, e.g.*, 42 U.S.C. §§ 238n(a), 300a-7(c). There is no statutory basis for concluding, as the district court did, that the conscience statutes include or adopt Title VII's undue hardship analysis. The conscience statutes do not incorporate any part of Title VII.[6]

Nor did Congress somehow silently incorporate Title VII into every other federal statute that touches on employment discrimination. *See, e.g., Gross v. FBL Fin. Servs., Inc.*, 557 U.S. 167, 174 (2009) (refusing to incorporate Title VII's "burden-shifting" analysis into the ADEA, given the difference between the statutes). As the Supreme Court has cautioned, courts "must be careful not to apply rules applicable under one statute to a different statute" unless circumstances dictate that the statutes be treated identically, *id.* at 174 (quotation marks omitted)—and there are no such rare circumstances here.

In reaching the contrary conclusion, the district court relied on the Supreme Court's decision in *Jackson v. Birmingham Board of Education*, 544 U.S. 167 (2005)—but that case *undermines* the district court's conclusion. In *Jackson*, the

[6] As the district court noted, the ACA includes a provision stating that it does not "alter" any rights or obligations "under title VII of the Civil Rights Act of 1964." 42 U.S.C. § 18023(c)(3). But this provision merely affirms that the ACA does not amend Title VII—it does *not* say that any part of the ACA (including its conscience-protection provision) silently incorporates Title VII's "undue hardship" framework.

defendant insisted that Title IX should be interpreted in light of Title VII—and that because Title VII *expressly* prohibited "retaliation" and Title IX did not include a parallel express prohibition, Title IX could not *impliedly* prohibit retaliation. *Id.* at 175. The Supreme Court rejected that argument, explaining that Title VII and Title IX are "vastly different," and the structure of Title VII offered no insight into the meaning of Title IX. *Id.*

Far from supporting the district court's conclusion that all federal legislation that touches on employment discrimination silently incorporates Title VII, *Jackson* undercuts it. And there is no textual indication in the conscience statutes that Congress intended to import Title VII's undue hardship framework. *See Gross*, 557 U.S. at 174 (courts "must be careful not to apply rules applicable under one statute to a different statute").

The conscience statutes stand on their own—they do not incorporate Title VII. *See id.* It necessarily follows that HHS did not act contrary to law by promulgating a regulation that does not incorporate Title VII either. If anything, a rule that *did* incorporate that framework would be invalid—because it would be contrary to the clear language of the conscience statutes. *See Giardino v. Comm'r*, 776 F.2d 406, 409 (2d Cir. 1985).

2. The Conscience Rule Does Not Conflict With EMTALA.

The district court also held that the Rule is contrary to law on the ground that it conflicts with EMTALA. But there is no conflict here either. "EMTALA was enacted to fill a lacuna in traditional state tort law by imposing on hospitals a legal duty (that the common law did not recognize) to provide emergency care to all." *Hardy v. New York City Health & Hosp. Corp.*, 164 F.3d 789, 792-93 (2d Cir. 1999). Contrary to the district court's view, the Conscience Rule does not conflict with this mandate that hospital emergency departments provide lifesaving treatment.

The district court found an implied conflict based on a concern that hospitals would find it expensive or difficult to comply with both EMTALA and the Rule. *See* SA 76-77. There is no evidence that is true, but even if it were, it would not amount to a conflict. A regulation is not invalid merely because it indirectly increases the cost of complying with other laws or regulations. *See Associated Builders & Contractors, Inc. v. Shiu*, 773 F.3d 257, 266 (D.C. Cir. 2014) (rejecting challenge that new labor regulations would be "especially difficult to comply with" because accepting such an argument "would doom virtually any regulation that imposes new obligations on regulated entities").

In all events, the district court's concern is unfounded. The court pointed to a comment submitted by the American College of Emergency Physicians speculating that "emergency departments do not have the budget or staffing capacity

'to be able to have additional personnel on hand 24 hours a day, 7 days a week to respond to different emergency situations that might arise involving patients with different backgrounds, sexual orientations, gender identities, or religious or cultural beliefs.'" SA 77. But this is not evidence that *any* medical professionals hold beliefs that would prevent them from providing lifesaving and stabilizing treatments.

The only evidence before the court on that score was from CMDA, which emphasized that its members provide lifesaving care to all patients, and that health care professionals have a duty to protect the patient's continuity of care, even when they object to a particular non-emergency procedure. JA 1489-90 ¶¶ 10-13. Indeed, HHS was "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." 73 Fed. Reg. at 78,087 *cited in* 84 Fed. Reg. 23,183 & n.51.[7] Certainly there was no such evidence in the administrative record.

Besides, the Supreme Court has made clear again and again that it is not enough for a challenger to point to speculation that a rule *could*, if applied under

[7] The district court adopted Plaintiffs' speculative claim that the Rule might be invoked by an ambulance driver who objects to surgery intended to treat complications from an ectopic pregnancy. *See* SA 76. But as CMDA explained, it does not have any objection to such lifesaving procedures—and CMDA's former CEO has personally treated many ectopic pregnancies to protect the life of the mother. JA 1491 ¶ 20. Moreover, there is no evidence in the record that *any* faith group prohibits its adherents from treating an ectopic pregnancy. JA 1491-93 ¶¶ 20-23; *see also* JA 1500 ¶¶ 14-15 (Dr. Frost is unaware of any physician with a religious objection to removing an ectopic pregnancy).

some hypothetical circumstance, violate the statute—the rule must violate the statute under *any* possible set of facts. *See EPA v. EME Homer City Generation, L.P.*, 572 U.S. 489, 524 (2014) ("The possibility that the rule, in uncommon particular applications, might exceed [the agency]'s statutory authority does not warrant judicial condemnation of the rule in its entirety."); *Am. Hosp. Ass'n v. NLRB*, 499 U.S. 606, 619 (1991) (merely "point[ing] to a hypothetical case in which the rule might lead to an arbitrary result does not render the rule" facially invalid).

Plaintiffs have not even attempted to make that difficult showing. Nor could they. Speculation that a hospital might need to use more staff to comply with both EMTALA and the Rule creates no conflict that could justify invalidating the Rule.

B. The Conscience Rule Is Not Arbitrary And Capricious.

The Rule is supported by a voluminous record compiled over the course of three different rulemakings. The Rule itself is detailed and comprehensive—spanning over a hundred pages in the Federal Register and laying out the reasons for HHS's decision, setting out the evidence supporting it, and addressing objections and concerns about it. It easily survives arbitrary-and-capricious review under 5 U.S.C. § 706(2)(A).

That scope of review is narrow. *EPSA*, 136 S. Ct. at 782; *State Farm*, 463 U.S. at 43. "A court is not to ask whether a regulatory decision is the best one possible or even whether it is better than the alternatives." *EPSA*, 136 S. Ct. at 782.

"Rather, the court must uphold a rule if the agency has 'examined the relevant considerations and articulated a satisfactory explanation for its action, including a rational connection between the facts found and the choice made.'" *Id.* (quoting *State Farm*, 463 U.S. at 43) (alterations adopted).

As the Supreme Court recently observed, courts "may not substitute [their] judgment for that of the [agency], but instead must confine [themselves] to ensuring that [it] remained 'within the bounds of reasoned decisionmaking.'" *Dep't of Commerce*, 139 S. Ct. at 2569 (citation omitted) (quoting *Balt. Gas & Elec. Co. v. Nat. Res. Def. Council, Inc.*, 462 U.S. 87, 105 (1983)). The Rule easily passes muster under this deferential test.

1. The Rule's Justifications Are Well Supported.

HHS offered page upon page of justifications for the Rule—summarizing the voluminous evidence the agency acquired over three successive rulemakings and explaining why it supported the regulation. *See supra*, at pp. 13-15, 17-20. The district court ignored all of this evidence and focused instead on two sentences that the district court believed were factually mistaken. This was error. There was no mistake, but even if there were, it would not be enough to invalidate the Rule.

The district court focused on a single statement that, in the district court's view, was "central" to HHS's decision to promulgate the Rule:

> Since November 2016, there has been a significant increase in complaints filed with OCR alleging violations

> of the laws that were the subject of the 2011 Rule, compared to the time period between the 2009 proposal to repeal the 2008 Rule and November 2016. The increase underscores the need for the Department to have the proper enforcement tools available to appropriately enforce all Federal conscience and anti-discrimination laws.

84 Fed. Reg. at 23,175. The district court believed that "HHS's claim of a significant increase" in complaints was "demonstrably false," thus invalidating the Rule entirely (SA 80-85); that the complaints HHS received did not justify the Rule's enforcement mechanisms (SA 85-87); and that the complaints failed to justify the "scope" of the Rule's definitions of terms used in the conscience statutes (SA 87-89). All three conclusions were erroneous.

First, the district court's conclusion that there was no significant increase in complaints was based on a mistaken premise. According to the court, HHS claimed there had been "343 such complaints" alleging violations of the conscience statutes during fiscal year 2018—yet only 20 or so complaints in this time period actually implicated the conscience statutes. SA 81-82. But the mathematical "false[hood]" identified by the district court does not exist. *Id.* HHS never claimed there were 343 complaints implicating the *conscience statutes*. HHS recounted that it had received 343 *total* complaints alleging "conscience violations" of *any sort*—not just those based on the conscience statutes—during FY 2018. 84 Fed. Reg. at 23,229. The district court did not dispute that conclusion. *See* SA 81.

HHS's more general statement that there had been "*a significant increase* in complaints filed with OCR" regarding the conscience statutes themselves was accurate as well. 84 Fed. Reg. at 23,175 (emphasis added). As the district court acknowledged, before late 2016, "HHS had received approximately one complaint per year related to the Conscience Provisions, whereas after the NPRM issued on January 26, 2018, that number of relevant complaints (by HHS's tabulation) increased to 10." SA 84. HHS could reasonably describe a tenfold increase in annual complaints as "significant"—especially given the deference owed to the agency's determinations.[8]

Besides, HHS hardly relied on that increase alone. HHS also referenced, for example:

- Thousands of complainants it received during the prior rulemakings (demonstrating that discrimination remained a problem);
- A 2009 survey of religious health care professionals disclosing that nearly 40% of the respondents faced pressure or discrimination "based on their moral, ethical, or religious beliefs";
- Several well-publicized incidents over the last decade of nurses being forced to perform abortions;

[8] The district court dismissed this increase, because it viewed the complaints filed after November 2016 as a reaction to HHS's proposed rule—not a reflection of a problem in the real world. SA 85. But as the court itself noted in a footnote, almost 70% of the post-2016 complaints identified by HHS were filed *before* it proposed a rulemaking. SA 84 n.51. Regardless, it is unclear why complaints filed after a rulemaking begins should be summarily discounted.

- Comments received in the most recent rulemaking demonstrating that discrimination in violation of the conscience statutes was still ongoing; and

- Recent litigation attempting to require religious objectors to perform abortions, notwithstanding the conscience statutes.

84 Fed. Reg. at 23,175-79. Even if the tenfold increase in complaints "may not be entirely convincing" as a justification for the Rule, it was, at worst, "superfluous" given HHS's numerous other justifications, and no basis for invalidating the Rule. *See Fox Television*, 556 U.S. at 517 ("superfluous" reasoning, even if not "entirely convincing," is irrelevant under arbitrary-and-capricious review); *see also Nat'l Ass'n of Home Builders v. Defs. of Wildlife*, 551 U.S. 644, 659 (2007) (a "stray statement, which could have had no effect on the underlying agency action being challenged" cannot be grounds to invalidate a rule justified by other evidence). Indeed, far from being HHS's "central" justification, HHS expressly stated that the increase in complaints was just "one of the many metrics" used to confirm the importance of the rule. 84 Fed. Reg. at 23,229.

The district court's determination that the complaints do not support the Rule's new enforcement tools fails for much the same reason. *See* SA 85-87. HHS identified pages of evidence that the conscience statutes were being disregarded by employers. *See* 84 Fed. Reg. at 23,175-79. That was sufficient—especially under the deferential standard of arbitrary-and-capricious review—to provide "a rational connection between the facts found and the choice made" by HHS to bolster its

means of enforcing the statutes. *EPSA*, 136 S. Ct. at 782 (quoting *State Farm*, 463 U.S. at 43).

Finally, the district court erred by holding that the complaints failed to justify the "scope" of the Rule's definitions of statutory terms. SA 87-89. The meaning of statutory terms is a legal question, not a factual one. *See* SA 87 (acknowledging that HHS argued its definitions were "textually defensible" under the statutes). HHS did not need to identify facts—in the complaints or otherwise—to support its legal analysis about the scope of the statutory terms. *See, e.g.*, *City of Arlington v. FCC*, 569 U.S. 290, 297 (2013) ("[T]he question a court faces when confronted with an agency's interpretation of a statute it administers is always, simply, whether the agency has stayed within the bounds of its statutory authority.").

2. The Agency Adequately Explained Its Decision To Depart From The Prior Administration's Rule.

When an agency adopts a new policy, the agency "need not demonstrate to a court's satisfaction that the reasons for the new policy are *better* than the reasons for the old one." *Fox Television*, 556 U.S. at 515. Instead, when an "agency shifts course, 'it suffices that the new policy is permissible under the statute, that there are good reasons for it, and that the agency *believes* it to be better, which the conscious change of course adequately indicates.'" *Mozilla Corp. v. FCC*, 940 F.3d 1, 50 (D.C. Cir. 2019) (quoting *Fox Television*, 556 U.S. at 515). The Rule easily satisfies that standard.

As already explained, the Rule was well reasoned and supported. *Supra*, at pp. 33-37. And HHS plainly "display[ed] awareness that it [was] changing position"—devoting page after page to explaining how and why it was doing so. *Fox Television*, 556 U.S. at 515. The Rule recounted both prior regulations in detail, and explained that HHS was choosing to depart from the 2011 Rule's "minimalistic" approach to a more comprehensive one that "reinstates the structure of the 2008 Rule, includes further definitions of terms, and provides robust certification and enforcement provisions comparable to provisions found in OCR's other civil rights regulations." 84 Fed. Reg. at 23,179, 23,228; *see also id.* at 23,254-55 (explaining why the agency was departing from "the status quo").

The district court had several complaints about HHS's departure from the prior regulatory regime, but none are cognizable under APA review and none justify invalidating the Rule.

a. HHS did not fail to address any contrary "factual findings" in the 2011 Rule. In *Fox Television*, the Supreme Court explained that a rule must include a "more detailed justification" if a "new policy rests upon factual findings that contradict those which underlay its prior policy." 556 U.S. at 515. In the district court's view, (i) HHS reached a "factual" conclusion in 2011 that the very act of defining statutory terms in a rule creates "confusion," and as a result (ii) HHS could not define statutory terms in the subsequent Conscience Rule without first

addressing its prior "factual" conclusion that definitions necessarily cause confusion. SA 92-93. But that is wrong on several levels.

First, HHS made no prior "factual" finding that the *legal* act of defining statutory terms causes confusion. The 2011 Rule simply explained that HHS was "rescind[ing] the definitions contained in the 2008 Final Rule because of concerns that they may have caused confusion regarding the scope of the federal health care provider conscience protection statutes." 76 Fed. Reg. at 9974. This was, at most, a *legal* conclusion about "the scope of the . . . conscience protection statues," which was used to support a *policy* decision that the agency would interpret the statutes on a case-by-case basis. *Id.* It was not a factual finding that imposed an obligation on the agency in all subsequent rulemakings to provide a "detailed justification" why, as a matter of policy, it was choosing to promulgate a legal definition in a rule. *See Fox Television*, 556 U.S. at 515; *id.* at 538 (Kennedy, J., concurring in part and concurring in the judgment) (when agency's prior policy was based on its view of the *law*, it necessarily "did *not* base its prior policy on factual findings" (emphasis added)).

Further, the notion that promulgating a definition of a previously undefined term inherently causes confusion makes little sense. If anything, the opposite is true. Providing detailed definitions of otherwise-undefined statutory terms helps *reduce* confusion about what the statute covers. *See, e.g.*, *Holder v. Humanitarian Law*

Project, 561 U.S. 1, 21 (2010) ("These definitions increased the clarity of the statute's terms."); *see also id.* at 20-21 (terms "*without* statutory definitions" are more likely to be confusing and "vague" (emphasis added) (first quoting *United States v. Williams*, 553 U.S. 285, 306 (2008)).

The D.C. Circuit's decision in *United Steel v. Mine Safety & Health Administration*, 925 F.3d 1279 (D.C. Cir. 2019), is not to the contrary. *See* SA 93-94 (relying on *United Steel*). There, the agency previously found that miners would be at a higher risk of exposure to unsafe hazards if mine-safety inspections were conducted *after* the miners started working. *See United Steel*, 925 F.3d at 1284 (holding the agency needed to address this finding before permitting later inspections). This empirical determination of the real-world consequences of regulated conduct bears no resemblance to the legal and policy question of whether it is desirable to use a regulation to define statutory terms. *See Fox Television*, 556 U.S. at 538 (Kennedy, J., concurring in part and concurring in the judgment) (agency's prior views on the law are not "factual findings").

b. HHS made no contrary finding about access to care. The district court similarly erred when it concluded that the Conscience Rule conflicts with earlier "factual findings" that rules including definitions of statutory terms somehow "limit access to care." SA 94-96. Again, the district court mistook a legal and policy disagreement for a factual dispute.

In 2011, HHS concluded that "the 2008 Final Rule . . . had the potential to negatively impact patient access to contraception and certain other medical services without a basis in federal conscience protection statutes." 76 Fed. Reg. at 9974. HHS did not elaborate on this conclusion, other than to note that (i) eight states had filed a lawsuit alleging that the 2008 Rule somehow prevented them "from enforcing their state laws concerning access to contraception," and (ii) the Medicaid program "require[s] that States provide contraceptive services to Medicaid beneficiaries." *Id.*[9]

In 2011, HHS did not lay out any facts detailing how the 2008 Rule *actually* decreased access to contraception or *actually* interfered with states that provided contraception to their citizens. Nor did it explain how the 2008 Rule could even *possibly* result in less access to "certain other medical services." *See id.* At most, HHS implied that the 2008 Rule had reduced "access" to some procedures—"contraception" and unspecified "certain other medical services"—by going beyond the protections of the statutes that the Rule was meant to enforce. *Id.* Indeed, that is the only way that the *Rule itself* could have decreased access—because if the Rule

[9] The plaintiffs who sued to invalidate the 2008 Rule include many of the same Plaintiffs here: New York, Connecticut, Illinois, New Jersey, Massachusetts, Rhode Island, Oregon, Planned Parenthood Federation of America, and the National Family Planning & Reproductive Health Association. *See Connecticut v. United States*, No. 09-cv-054 (D. Conn.).

was within the scope of the statutes, then it would be the *statutes* decreasing access, not the Rule.

HHS's vague statement about access was at most a legal conclusion that the 2008 Rule was overbroad and unauthorized by the conscience statutes. *See id.* As a result, to the extent Plaintiffs are making a similar argument now about the Conscience Rule, they are challenging legal conclusions, not "factual findings." *Fox Television*, 556 U.S. at 515. The district court erred in concluding otherwise.

c. HHS explained why it believed the 2011 Rule caused confusion and demonstrated that conscience protections do not decrease access to care. Because HHS did not contradict any prior factual findings, it was not obligated to offer "a more detailed justification [for the Rule] than what would suffice for a new policy created on a blank slate." *Id.* at 515. But even if HHS were under such an obligation, it satisfied it.

HHS explained that post-2011 evidence revealed that the 2011 Rule created greater confusion by eliminating all definitions explaining the scope of the conscience statutes, *see* 84 Fed. Reg. at 23,175-79, and pointed to post-2011 studies debunking the notion that promulgating regulations reinforcing the conscience protections would limit access to care, *see id.* at 23,180 & n.45. Consequently, even if HHS's discussions of "confusion" and "access to care" in the 2011 rulemaking were treated as factual findings—rather than legal conclusions or policy

determinations—HHS "adequately explained how new information arising after the [2011 Rule] informed its conclusion" to depart from those "findings." *Mingo Logan Coal Co. v. EPA*, 829 F.3d 710, 727 (D.C. Cir. 2016).

d. HHS did not ignore serious reliance interests. The district court further faulted the Conscience Rule for ignoring "serious reliance interests" of employers upon the prior rule's interpretation of the conscience statutes. SA 98-99. Although the disruption of reliance interests does not, on its own, invalidate a rule, it does trigger a heightened obligation to justify the rule. *See Fox Television*, 556 U.S. at 515. But that burden is not triggered here.

For reliance interests to arise, there must be something on which to rely—in this context, an agency interpretation of the law that regulated entities can plan their behavior around. *See, e.g.*, *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126 (2016) (employers relied on agency's prior interpretation of the Fair Labor Standards Act). But the 2011 Rule expressly *declined* to interpret the scope or reach of the federal conscience statutes—it left the statutes' terms undefined. 76 Fed. Reg. at 9974. ("The Department is not formulating new definitions [of statutory terms].").

Nor did the 2011 Rule endorse or condemn any behavior in a way that might give rise to reliance interests—it merely said that "[e]ntities must continue to comply with the Federal health care provider conscience protection statutes." *Id.* The 2011 Rule only told employers to follow the law—it did not explain what that law *is*, and

thus did not give regulated entities any statutory guidance on which they could have relied (justifiably or otherwise).

3. HHS Considered Important Aspects Of The Problem.

The district court also erred when it concluded that the Rule was invalid because HHS failed to consider important aspects of the problem presented—namely, in the district court's view, the Rule's interaction with Title VII and EMTALA. SA 103. "While agency action may be overturned as arbitrary and capricious if the agency '*entirely* failed to consider an important aspect of the problem' at issue, a court will not 'lightly' reach that conclusion." *New York v. Dep't of Justice*, 951 F.3d 84, 122 (2d Cir. 2020) (emphasis added) (internal citation omitted) (first quoting *State Farm*, 463 U.S. at 43, then quoting *Islander E. Pipeline Co. v. McCarthy*, 525 F.3d 141, 151 (2d Cir. 2008)).

Here, HHS "did not 'fail[] to consider'" a "problem" arising from Title VII and EMTALA because it "acknowledged comments" about the purported problem and decided that other considerations outweighed the concerns raised in these comments. *See Owner-Operator Indep. Drivers Ass'n, Inc. v. Fed. Motor Carrier Safety Admin.*, 494 F.3d 188, 210 (D.C. Cir. 2007). As the district court recognized, HHS responded directly to comments raising concerns about the proposed rule's interaction with Title VII and EMTALA, and defended its approach. *See* SA 104-05, 107 (citing 84 Fed. Reg. at 23,183, 23,188, 23,191). That is all the APA requires.

One "may disagree with [the agency's] policy balance, but it does not reflect a failure to consider relevant factors." *Owner-Operator*, 494 F.3d at 211.[10]

Yet, while acknowledging that HHS addressed comments about Title VII and EMTALA, the district court concluded that HHS violated the APA because it failed "*adequately*" to consider those concerns. SA 103 (emphasis added). But an agency need only be "aware" of a problem and not "entirely" overlook it. *See Dep't of Justice*, 951 F.3d at 122. There is no question HHS satisfied that requirement here. Requiring more runs the risk of going beyond the bounds of the APA's procedural framework to consider whether a particular policy is preferable—and the Supreme Court has repeatedly cautioned that arbitrary-and-capricious review provides no license to engage in policy second-guessing. *See EPSA*, 136 S. Ct. at 782 ("A court is not to ask whether a regulatory decision is the best one possible or even whether it is better than the alternatives."); *State Farm*, 463 U.S. at 43 ("[A] court is not to substitute its judgment for that of the agency."). The district court's determination that HHS's consideration of the issue was not "adequate[]" was error. *See* SA 109.

C. The Final Rule Is A Logical Outgrowth Of The Proposed Rule.

For APA purposes, a final rule "need not be an exact replica of the rule proposed"—it is enough if the final rule is "only a logical outgrowth" of the

[10] As explained, Title VII and EMTALA do not pose any legal obstacle to the Rule. *Supra*, at pp. 27-32.

proposed rule. *Cooling Water Intake Structure Coal. v. EPA*, 905 F.3d 49, 61 (2d Cir. 2018) (internal quotation marks omitted). Whether a final rule is a logical outgrowth of the proposed rule turns on "whether the agency's notice would fairly apprise interested persons of the subjects and issues of the rulemaking." *Id.* (quoting *Nat'l Black Media Coal. v. FCC*, 791 F.2d 1016, 1022 (2d Cir. 1986)). The Conscience Rule clears that bar.

The district court held that the Rule was not a "logical outgrowth" of the 2018 rule proposal (and thus violated the APA's notice requirement) solely because, in the district court's view, Title VII governs or supersedes the conscience statutes and the Rule failed to address Title VII. *See* SA 112 (faulting HHS for "provid[ing] no hint that HHS was considering overriding the Title VII reasonable accommodation / undue hardship framework"). Because, as already explained, the court's Title VII premise is flawed, *see supra*, at pp. 27-29, its logical-outgrowth conclusion is too. Title VII does not govern the Rule, and there was no need to address Title VII in the notice of proposed rulemaking.

II. The Conscience Rule Does Not Violate The Spending Clause.

The Spending Clause governs Congress's ability to place conditions on the funds it grants to the states. *See* U.S. Const. art. I, § 8, cl. 1; *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 16 (1981). The district court held that the Rule

violates the Spending Clause, but the Rule merely restates the funding restrictions in the conscience statutes—and no one questions the statutes' constitutionality.

The district court incorrectly reasoned that the Rule imposes new restrictions *beyond* those already present in the conscience statutes. *See* SA 125-26 (finding the Rule "add[s]" new "substantive conditions"). The Rule merely defines statutory terms using their ordinary meaning. *See* Gov. Br. 28-37; *see also* 84 Fed. Reg. at 23,200 (noting that Rule's definition of "refer" comports with dictionary definitions of the term). This does not impose new *extra-statutory* funding restrictions—it merely makes the meaning of the restrictions in those statutes explicit. *See Pioneer Inv. Servs. Co. v. Brunswick Assocs. Ltd. P'ship*, 507 U.S. 380, 388 (1993) (statutory terms are presumed "to carry their ordinary, contemporary, common meaning"); *Dep't of Justice*, 951 F.3d at 106 (when a word "is not statutorily defined," "it is properly construed according to its contemporary dictionary definition"). Because the restrictions in the statutes are constitutional, the Rule restating those restrictions is constitutional as well.[11]

CONCLUSION

For the foregoing reasons, the judgment should be reversed and rendered for appellants.

[11] The district court also held that the Rule violates the Spending Clause by "conflict[ing] with . . . Title VII and EMTALA." SA 126. As explained, there is no conflict. *Supra*, at pp. 27-32.

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Fed. R. App. P. 32(a)(7)(B)(i) and Local Rule 32.1(a)(4)(A) because, excluding the parts of the document exempted by Fed. R. App. P. 32(f), this brief contains 11,066 words.

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Date: April 27, 2020

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Second Circuit by using the appellate CM/ECF system on April 30, 2020. I certify that all participants in the case who are registered CM/ECF users will be served by the appellate CM/ECF system.

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