Nos. 20-15398, 20-15399, 20-16045 and 20-35044

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

CITY AND COUNTY OF SAN FRANCISCO, *Plaintiff-Appellee*,
v.
ALEX M. AZAR II, et al., *Defendants-Appellants*.

COUNTY OF SANTA CLARA, et al., *Plaintiffs-Appellees*,
v.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants-Appellants*.

STATE OF CALIFORNIA, *Plaintiff-Appellee*,
v.
ALEX M. AZAR, et al., *Defendants-Appellants*.

STATE OF WASHINGTON, *Plaintiff-Appellee*,
v.
ALEX M. AZAR II, et al., *Defendants-Appellants*.

On Appeal from the United States District Courts for the
Northern District of California and the Eastern District of Washington

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SUPPLEMENTAL EXCERPTS OF RECORD
VOLUME IV OF X

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Exhibit 396

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of the Secretary

Director
Office for Civil Rights
Washington, D.C. 20201

June 21, 2016

SENT VIA U.S. MAIL AND ELECTRONIC MAIL

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Michelle (Shelley) Rouillard, Director
California Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

Re: OCR Transaction Numbers: 14-193604, 15-193782, & 15-195665

Dear Ms. Short, Mr. Bowman, Mr. Mattox, Mr. Sweeney, and Ms. Rouillard:

The Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services (HHS) has concluded its investigation of allegations that the California Department of Managed Health Care (CDMHC) engaged in discrimination under the Weldon Amendment[1] by issuing letters to several health insurers directing them to amend their plan documents to remove coverage exclusions and limitations regarding elective abortions. OCR received three complaints challenging the CDMHC letter, filed on behalf of a religious organization, churches and a

[1] Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, Div. H, Sec. 507(d) (Dec. 18, 2015).

church-run school, and employees of a religiously-affiliated university. The following sets forth the results of our investigation of these complaints.

Background

On August 22, 2014, the Director of CDMHC notified seven California health insurance plans[2] that it had come to CDMHC's attention that each of them had issued insurance contracts that limited or excluded coverage for termination of pregnancies. CDMHC regulates health care service plans under the Knox-Keene Health Care Service Plan Act of 1975 (Act), Cal. Health & Safety Code Sections 1340-1399.864, and its letter directed each health insurer to ensure that its health plans complied with the Act's requirement to cover legal abortions. CDMHC required the insurers to amend plan documents to remove coverage exclusions and limitations for "voluntary" or "elective" abortions and any limitations on coverage to only "therapeutic" or "medically necessary" abortions and to file revised documents within 90 days. A footnote in the letter stated that "no individual health care provider, religiously sponsored health carrier, or health care facility may be required by law or contract in any circumstance to participate in the provision of or payment for a specific service if they object to doing so for reason of conscience or religion."

Implementing regulations of the Federal Health Care Provider Conscience Laws designate OCR as the office to receive complaints alleging discrimination under the Weldon Amendment. 45 C.F.R. § 88.2. OCR investigated each of the three complaints it received about the CDMHC letter, including requesting, receiving, and analyzing a written response to the complaints from CDMHC; collecting additional information from the complainants; interviewing each of the seven health insurers contacted by CDMHC, some on several occasions; and engaging in follow-up conversations with CDMHC.

OCR's investigation found that each of the insurers that received the CDMHC letter had, at the time it received the letter, included coverage for voluntary abortions in plans that it offered; upon receipt of the letter, each amended its plan documents by CDMHC's deadline to eliminate the subject exclusions from any plans that contained them. None of the insurers asserted any objection to offering coverage for voluntary abortion services and none identified any religious or moral objection that it had to such coverage.

OCR's investigation also found that Blue Cross of California (dba Anthem Blue Cross) subsequently sought and received from CDMHC an exemption to allow it to offer a plan excluding elective abortion services for religious employers as defined under California law. Cal. Health & Safety Code Section 1367.25(c)(1). As a result, CDMHC has demonstrated its willingness to authorize insurers to offer products that exclude coverage for elective abortion to such religious employers.

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[2] The seven health insurance plans were Aetna Health of California, Inc.; Blue Cross of California, dba Anthem Blue Cross; California Physicians' Service, dba Blue Shield of California; GEMCare Health Plan, Inc., dba ERD, Inc., Physicians Choice by GEMCare Health Plan; Health Net of California, Inc.; Kaiser Foundation Health Plan, Inc., dba Kaiser Foundation, Permanente Medical Care Program; and United Healthcare of California. OCR understands that GEMCare is no longer participating in the commercial insurance marketplace.

The Weldon Amendment

The Weldon Amendment provides:

> (d)(1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.
>
> (2) In this subsection, the term "health care entity" includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.[3]

The amendment was passed to protect health care entities covered by the amendment from discrimination where those entities object to abortion on religious or moral grounds. *See State of California v. Lockyer*, 450 F.3d 436, 441 (9th Cir. 2006) ("Congress passed the Weldon Amendment precisely to keep doctors who have moral qualms about performing abortions from being put to the hard choice of acting in conformity with their beliefs or risking imprisonment or loss of professional livelihood").

The amendment applies only to health care entities as defined therein. As the primary sponsor of the amendment, Representative Weldon himself made clear in discussing its scope:

> This provision is intended to protect the decisions of physicians, nurses, clinics, hospitals, medical centers, and even health insurance providers from being forced by the government to provide, refer, or pay for abortions. . . . It explicitly clarifies existing law to state that a health care entity includes a hospital, a health professional, a provider-sponsored organization, a health maintenance organization, a health insurance plan or any other kind of health care facility. It goes on further to state that existing law protects health care entities from discrimination based on three kinds of participation in abortion: performing, training and referring.[4]

Representative Weldon further stated that the health care entities that are protected are those that "choose not to provide abortion services."[5] In making clear that the amendment protects those who object to the provision of abortions, he stated, "[t]he Hyde-Weldon amendment . . . simply states you cannot force the unwilling" to participate in elective abortions. "The amendment does not apply to willing abortion providers."[6]

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[3] Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, Div. H, Sec. 507(d) (Dec. 18, 2015).
[4] 150 Cong. Rec. H10090 (Statement of Rep. Weldon) (Nov. 20, 2004).
[5] *Id.*
[6] 151 Cong. Rec. H177 (Statement of Rep. Weldon) (Jan. 25, 2005).

Representative Weldon also made clear that the health care entities protected under the amendment are those that have objections based on religious or moral grounds:

> [The Weldon Amendment] is a continuation of the Hyde policy of conscience protection. . . . The right of conscience is fundamental to our American freedoms. We should guarantee this freedom by protecting all health care providers from being forced to perform, refer, or pay for elective abortions.[7]

Findings

CDMHC is an agency and instrumentality of the State, and thus an entity to which the terms of the Weldon Amendment apply. The State of California receives federal funding under the Appropriations Act that includes the Weldon Amendment.[8] The seven health insurers to which CDMHC sent the August 22, 2014 letter meet the definition of "health care entity" in the Weldon Amendment, as each is a "health insurance plan." Based on the facts provided to OCR, none of the complainants meets the definition of a "health care entity" under the Weldon Amendment.

By its plain terms, the Weldon Amendment's protections extend only to health care entities and not to individuals who are patients of, or institutions or individuals that are insured by, such entities. In addition, its author, Representative Weldon, made clear both that the amendment protects only those covered health care entities that object to the provision of abortions and that its basic purpose is to protect those entities whose objections are made on religious or moral grounds.

Here, none of the seven insurers that received the CDMHC letter – the entities that are covered under the Weldon Amendment – objected to providing coverage for abortions. All modified their plan documents to cover voluntary abortion in response to the CDMHC letter, and none has indicated to OCR that it has a religious or moral objection to abortion or to providing coverage for abortion in the products it offers. Indeed, as noted above, at the time CDMHC sent the letter, all of the insurers offered plans that covered abortion, demonstrating that they have no religious or moral objection to that procedure. As a result, there is no health care entity protected under the statute that has asserted religious or moral objections to abortion and therefore there is no covered entity that has been subject to discrimination within the meaning of the Weldon Amendment.[9]

We further note that the approach described above avoids a potentially unconstitutional application of the amendment. A finding that CDMHC has violated the Weldon Amendment might require the government to rescind all funds appropriated under the Appropriations Act to

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[7] 150 Cong. Rec. H10090 (Statement of Rep. Weldon) (Nov. 20, 2004).
[8] Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, Div. H, Sec. 507(d) (Dec. 18, 2015).
[9] We reiterate that to the extent that entities whose religious beliefs are not protected under the Weldon Amendment nonetheless object to CDMHC's letter, CDMHC has demonstrated its willingness to authorize insurers to offer products that exclude coverage for elective abortion to entities that qualify as religious employers under California law. *See* discussion of Anthem Blue Cross *supra*. Some employers may also, of course, decide to self-insure; self-insured plans are not subject to the CDMHC policy.

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. HHS' Office of General Counsel, after consulting with the Department of Justice, has advised that such a rescission would raise substantial questions about the constitutionality of the Weldon Amendment. Specifically, in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012), the Supreme Court ruled that Congress could not condition a State's preexisting Medicaid funding on the State's compliance with an Affordable Care Act requirement to expand the program to include all low-income adults. The Court reasoned that this threat to terminate significant independent grants was so coercive as to deprive States of any meaningful choice whether to accept the condition attached to receipt of federal funds. Following accepted canons of statutory construction, OCR's approach, which is consistent with the views of the primary sponsor of the amendment, avoids this potentially unconstitutional application of the statute. *See Gomez v. United States*, 490 U.S. 858, 864 (1989).

Accordingly, OCR is closing its investigation of these complaints without further action.

Advisements

The determinations in this letter are not intended, nor should they be construed, to cover any issues regarding CDMHC's compliance with the Weldon Amendment that are not specifically addressed in this letter. It neither covers issues or authorities not specifically addressed herein nor precludes future determinations about compliance that are based on subsequent investigations.

The complainant has the right not to be intimidated, threatened, or coerced by a covered entity or other person because he or she has made a complaint, testified, assisted, or participated in any manner in an investigation, proceeding, or hearing held in connection with a complaint. Please take all necessary steps to ensure that no adverse action is taken against the complainants or any other individual for the filing of this complaint, providing information to OCR, or otherwise participating in this investigation.

Under the Freedom of Information Act, it may be necessary to release this document and related correspondence and records upon request. In the event OCR receives such a request, we will seek to protect, to the extent provided by law, personal information which, if released, would constitute an unwarranted invasion of privacy.

Sincerely,

Jocelyn Samuels
Director, Office for Civil Rights

cc: Gabriel Ravel
Deputy Director, General Counsel
California Department of Managed Health Care

Exhibit 398

DEPARTMENT OF
Managed
Health Care

Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency

Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725
Phone: (916) 324-8176
Fax: (916) 255-5241

August 22, 2014

VIA ELECTRONIC MAIL & U.S. MAIL

Mark Morgan
California President of Anthem Blue Cross
Blue Cross of California, dba Anthem Blue Cross
21555 Oxnard Street
Woodland Hills, CA 91367

Re: Limitations or Exclusions of Abortion Services

Dear Mr. Morgan:

It has come to the attention of the Department of Managed Health Care (DMHC) that some Blue Cross of California (Blue Cross) contracts contain language that may discriminate against women by limiting or excluding coverage for termination of pregnancies. The DMHC has reviewed the relevant legal authorities and has concluded that it erroneously approved or did not object to such discriminatory language in some evidence of coverage (EOC) filings. The DMHC has performed a survey and has discovered that such language is present in EOCs for products covering a very small fraction of California health plan enrollees.

The purpose of this letter is to remind plans that the Knox-Keene Health Care Service Plan Act of 1975[1] (Knox Keene Act) requires the provision of basic health care services and the California Constitution prohibits health plans from discriminating against women who choose to terminate a pregnancy. Thus, all health plans must treat maternity services and legal abortion neutrally.

Exclusions and limitations are also incompatible with both the California Reproductive Privacy Act and multiple California judicial decisions that have unambiguously established under the California Constitution that every pregnant woman has the fundamental right to choose to either bear a child or to have a legal abortion.[2,3] A health plan is not required to cover abortions that would be unlawful under Health & Safety Code § 123468.

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[1] Health & Safety Code § 1340, et seq.
[2] Consistent with 42 U.S.C. § 18054(a)(6), this letter shall not apply to a Multi-State Plan.
[3] Although health plans are required to cover legal abortions, no individual health care provider, religiously sponsored health carrier, or health care facility may be required by law or contract in any circumstance to participate in the provision of or payment for a specific service if they object to doing so for reason of conscience or religion. No person may be discriminated against in employment or professional privileges because of such objections.

DEPARTMENT OF
Managed
Health Care

Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency

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August 22, 2014

VIA ELECTRONIC MAIL & U.S. MAIL

John Ternan
President of Aetna Health of California, Inc.
Aetna Health of California, Inc.
2625 Shadelands Drive
Walnut Creek, CA 94898

Re: Limitations or Exclusions of Abortion Services

Dear Mr. Ternan:

It has come to the attention of the Department of Managed Health Care (DMHC) that some Aetna Health of California, Inc. (Aetna) contracts contain language that may discriminate against women by limiting or excluding coverage for termination of pregnancies. The DMHC has reviewed the relevant legal authorities and has concluded that it erroneously approved or did not object to such discriminatory language in some evidence of coverage (EOC) filings. The DMHC has performed a survey and has discovered that such language is present in EOCs for products covering a very small fraction of California health plan enrollees.

The purpose of this letter is to remind plans that the Knox-Keene Health Care Service Plan Act of 1975[1] (Knox Keene Act) requires the provision of basic health care services and the California Constitution prohibits health plans from discriminating against women who choose to terminate a pregnancy. Thus, all health plans must treat maternity services and legal abortion neutrally.

Exclusions and limitations are also incompatible with both the California Reproductive Privacy Act and multiple California judicial decisions that have unambiguously established under the California Constitution that every pregnant woman has the fundamental right to choose to either bear a child or to have a legal abortion.[2,3] A health plan is not required to cover abortions that would be unlawful under Health & Safety Code § 123468.

---

[1] Health & Safety Code § 1340, et seq.
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[3] Although health plans are required to cover legal abortions, no individual health care provider, religiously sponsored health carrier, or health care facility may be required by law or contract in any circumstance to participate in the provision of or payment for a specific service if they object to doing so for reason of conscience or religion. No person may be discriminated against in employment or professional privileges because of such objections.

Regardless of existing EOC language, effective as of the date of this letter, Aetna must comply with California law with respect to the coverage of legal abortions.

Required Action

1. Aetna must review all current health plan documents to ensure that they are compliant with the Knox-Keene Act with regard to legal abortion. This includes plan documents previously approved or not objected to by the DMHC.

   In regards to coverage for abortion services, the descriptors cited below are inconsistent with the Knox-Keene Act and the California Constitution. Aetna must amend current health plan documents to remove discriminatory coverage exclusions and limitations. These limitations or exclusions include, but are not limited to, any exclusion of coverage for "voluntary" or "elective" abortions and/or any limitation of coverage to only "therapeutic" or "medically necessary" abortions. Aetna may, consistent with the law, omit any mention of coverage for abortion services in health plan documents, as abortion is a basic health care service.

2. To demonstrate compliance, health plans are directed to file any revised relevant health plan documents (e.g. EOCs, subscriber documents, etc.) with the Department as an Amendment to the health plan's license within 90 days of the date of this letter. The filing should highlight as well as underline the changes to the text as required by the California Code of Regulations, title 28, §1300.52(d).

Authority Cited

California Constitution, article 1, section 1; Health and Safety Code §1340, et seq. and Health and Safety Code §123460 et seq., and implementing regulations.

If you have any questions concerning the guidance issued in this letter, please contact your Plan's Office of Plan Licensing reviewer.

Sincerely,

Michelle Rouillard

MICHELLE ROUILLARD
Director
Department of Managed Health Care

cc: Mary V. Anderson, Western Region General Counsel, Aetna Health of California, Inc.

DEPARTMENT OF
Managed
Health Care

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State of California
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August 22, 2014

VIA ELECTRONIC MAIL & U.S. MAIL

Paul Markovich
President and Chief Executive Officer
California Physicians' Service, dba Blue Shield of California
50 Beale Street
San Francisco, CA 94105

Re: Limitations or Exclusions of Abortion Services

Dear Mr. Markovich:

It has come to the attention of the Department of Managed Health Care (DMHC) that some California Physicians' Service, dba Blue Shield of California (Blue Shield) contracts contain language that may discriminate against women by limiting or excluding coverage for termination of pregnancies. The DMHC has reviewed the relevant legal authorities and has concluded that it erroneously approved or did not object to such discriminatory language in some evidence of coverage (EOC) filings. The DMHC has performed a survey and has discovered that such language is present in EOCs for products covering a very small fraction of California health plan enrollees.

The purpose of this letter is to remind plans that the Knox-Keene Health Care Service Plan Act of 1975[1] (Knox Keene Act) requires the provision of basic health care services and the California Constitution prohibits health plans from discriminating against women who choose to terminate a pregnancy. Thus, all health plans must treat maternity services and legal abortion neutrally.

Exclusions and limitations are also incompatible with both the California Reproductive Privacy Act and multiple California judicial decisions that have unambiguously established under the California Constitution that every pregnant woman has the fundamental right to choose to either bear a child or to have a legal abortion.[2,3] A health plan is not required to cover abortions that would be unlawful under Health & Safety Code § 123468.

[1] Health & Safety Code § 1340, et seq.
[2] Consistent with 42 U.S.C. § 18054(a)(6), this letter shall not apply to a Multi-State Plan.
[3] Although health plans are required to cover legal abortions, no individual health care provider, religiously sponsored health carrier, or health care facility may be required by law or contract in any circumstance to participate in the provision of or payment for a specific service if they object to doing so for reason of conscience or religion. No person may be discriminated against in employment or professional privileges because of such objections.

Regardless of existing EOC language, effective as of the date of this letter, Blue Shield must comply with California law with respect to the coverage of legal abortions.

Required Action

1. Blue Shield must review all current health plan documents to ensure that they are compliant with the Knox-Keene Act with regard to legal abortion. This includes plan documents previously approved or not objected to by the DMHC.

   In regards to coverage for abortion services, the descriptors cited below are inconsistent with the Knox-Keene Act and the California Constitution. Blue Shield must amend current health plan documents to remove discriminatory coverage exclusions and limitations. These limitations or exclusions include, but are not limited to, any exclusion of coverage for "voluntary" or "elective" abortions and/or any limitation of coverage to only "therapeutic" or "medically necessary" abortions. Blue Shield may, consistent with the law, omit any mention of coverage for abortion services in health plan documents, as abortion is a basic health care service.

2. To demonstrate compliance, health plans are directed to file any revised relevant health plan documents (e.g. EOCs, subscriber documents, etc.) with the Department as an Amendment to the health plan's license within 90 days of the date of this letter. The filing should highlight as well as underline the changes to the text as required by the California Code of Regulations, title 28, §1300.52(d).

Authority Cited

California Constitution, article 1, section 1; Health and Safety Code §1340, et seq. and Health and Safety Code §123460 et seq., and implementing regulations.

If you have any questions concerning the guidance issued in this letter, please contact your Plan's Office of Plan Licensing reviewer.

Sincerely,

Michelle Rouillard

MICHELLE ROUILLARD
Director
Department of Managed Health Care

cc: Kathleen Lynaugh, Associate General Counsel, California Physicians' Service, dba Blue Shield of California

DEPARTMENT OF
Managed
Health Care

Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency

Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725
Phone: (916) 324-8176
Fax: (916) 255-5241

August 22, 2014

VIA ELECTRONIC MAIL & U.S. MAIL

Michael Myers
Chief Executive Officer
GEMCare Health Plan, Inc., dba ERD, Inc., Physicians Choice by GEMCare Health Plan
4550 California Avenue, Suite 100
Bakersfield, CA 93309

Re: Limitations or Exclusions of Abortion Services

Dear Mr. Myers:

It has come to the attention of the Department of Managed Health Care (DMHC) that some GEMCare Health Plan, Inc., dba ERD, Inc., Physicians Choice by GEMCare Health Plan (GEMCare) contracts contain language that may discriminate against women by limiting or excluding coverage for termination of pregnancies. The DMHC has reviewed the relevant legal authorities and has concluded that it erroneously approved or did not object to such discriminatory language in some evidence of coverage (EOC) filings. The DMHC has performed a survey and has discovered that such language is present in EOCs for products covering a very small fraction of California health plan enrollees.

The purpose of this letter is to remind plans that the Knox-Keene Health Care Service Plan Act of 1975[1] (Knox Keene Act) requires the provision of basic health care services and the California Constitution prohibits health plans from discriminating against women who choose to terminate a pregnancy. Thus, all health plans must treat maternity services and legal abortion neutrally.

Exclusions and limitations are also incompatible with both the California Reproductive Privacy Act and multiple California judicial decisions that have unambiguously established under the California Constitution that every pregnant woman has the fundamental right to choose to either bear a child or to have a legal abortion.[2,3] A health plan is not required to cover abortions that would be unlawful under Health & Safety Code § 123468.

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[1] Health & Safety Code § 1340, et seq.
[2] Consistent with 42 U.S.C. § 18054(a)(6), this letter shall not apply to a Multi-State Plan.
[3] Although health plans are required to cover legal abortions, no individual health care provider, religiously sponsored health carrier, or health care facility may be required by law or contract in any circumstance to participate in the provision of or payment for a specific service if they object to doing so for reason of conscience or religion. No person may be discriminated against in employment or professional privileges because of such objections.

Regardless of existing EOC language, effective as of the date of this letter, GEMCare must comply with California law with respect to the coverage of legal abortions.

Required Action

1. GEMCare must review all current health plan documents to ensure that they are compliant with the Knox-Keene Act with regard to legal abortion. This includes plan documents previously approved or not objected to by the DMHC.

   In regards to coverage for abortion services, the descriptors cited below are inconsistent with the Knox-Keene Act and the California Constitution. GEMCare must amend current health plan documents to remove discriminatory coverage exclusions and limitations. These limitations or exclusions include, but are not limited to, any exclusion of coverage for "voluntary" or "elective" abortions and/or any limitation of coverage to only "therapeutic" or "medically necessary" abortions. GEMCare may, consistent with the law, omit any mention of coverage for abortion services in health plan documents, as abortion is a basic health care service.

2. To demonstrate compliance, health plans are directed to file any revised relevant health plan documents (e.g. EOCs, subscriber documents, etc.) with the Department as an Amendment to the health plan's license within 90 days of the date of this letter. The filing should highlight as well as underline the changes to the text as required by the California Code of Regulations, title 28, §1300.52(d).

Authority Cited

California Constitution, article 1, section 1; Health and Safety Code §1340, et seq. and Health and Safety Code §123460 et seq., and implementing regulations.

If you have any questions concerning the guidance issued in this letter, please contact your Plan's Office of Plan Licensing reviewer.

Sincerely,

Michelle Rouillard

MICHELLE ROUILLARD
Director
Department of Managed Health Care

DEPARTMENT OF
Managed
Health Care

Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency

Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725
Phone: (916) 324-8176
Fax: (916) 255-5241

August 22, 2014

VIA ELECTRONIC MAIL & U.S. MAIL

Steven Sell
President, Western Region Health Plan and President, Health Net of California, Inc.
Health Net of California, Inc.
21281 Burbank Blvd.
Woodland Hills, CA 91367

Re: Limitations or Exclusions of Abortion Services

Dear Mr. Sell:

It has come to the attention of the Department of Managed Health Care (DMHC) that some Health Net of California, Inc. (Health Net) contracts contain language that may discriminate against women by limiting or excluding coverage for termination of pregnancies. The DMHC has reviewed the relevant legal authorities and has concluded that it erroneously approved or did not object to such discriminatory language in some evidence of coverage (EOC) filings. The DMHC has performed a survey and has discovered that such language is present in EOCs for products covering a very small fraction of California health plan enrollees.

The purpose of this letter is to remind plans that the Knox-Keene Health Care Service Plan Act of 1975[1] (Knox Keene Act) requires the provision of basic health care services and the California Constitution prohibits health plans from discriminating against women who choose to terminate a pregnancy. Thus, all health plans must treat maternity services and legal abortion neutrally.

Exclusions and limitations are also incompatible with both the California Reproductive Privacy Act and multiple California judicial decisions that have unambiguously established under the California Constitution that every pregnant woman has the fundamental right to choose to either bear a child or to have a legal abortion.[2,3] A health plan is not required to cover abortions that would be unlawful under Health & Safety Code § 123468.

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[1] Health & Safety Code § 1340, et seq.
[2] Consistent with 42 U.S.C. § 18054(a)(6), this letter shall not apply to a Multi-State Plan.
[3] Although health plans are required to cover legal abortions, no individual health care provider, religiously sponsored health carrier, or health care facility may be required by law or contract in any circumstance to participate in the provision of or payment for a specific service if they object to doing so for reason of conscience or religion. No person may be discriminated against in employment or professional privileges because of such objections.

Regardless of existing EOC language, effective as of the date of this letter, Health Net must comply with California law with respect to the coverage of legal abortions.

Required Action

1. Health Net must review all current health plan documents to ensure that they are compliant with the Knox-Keene Act with regard to legal abortion. This includes plan documents previously approved or not objected to by the DMHC.

   In regards to coverage for abortion services, the descriptors cited below are inconsistent with the Knox-Keene Act and the California Constitution. Health Net must amend current health plan documents to remove discriminatory coverage exclusions and limitations. These limitations or exclusions include, but are not limited to, any exclusion of coverage for "voluntary" or "elective" abortions and/or any limitation of coverage to only "therapeutic" or "medically necessary" abortions. Health Net may, consistent with the law, omit any mention of coverage for abortion services in health plan documents, as abortion is a basic health care service.

2. To demonstrate compliance, health plans are directed to file any revised relevant health plan documents (e.g. EOCs, subscriber documents, etc.) with the Department as an Amendment to the health plan's license within 90 days of the date of this letter. The filing should highlight as well as underline the changes to the text as required by the California Code of Regulations, title 28, §1300.52(d).

Authority Cited

California Constitution, article 1, section 1; Health and Safety Code §1340, et seq. and Health and Safety Code §123460 et seq., and implementing regulations.

If you have any questions concerning the guidance issued in this letter, please contact your Plan's Office of Plan Licensing reviewer.

Sincerely,

Michelle Rouillard

MICHELLE ROUILLARD
Director
Department of Managed Health Care

cc: Douglas Schur, Vice President, Chief Regulatory Counsel, Health Net of California, Inc.

DEPARTMENT OF
Managed
Health Care

Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency

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August 22, 2014

VIA ELECTRONIC MAIL & U.S. MAIL

Wade J. Overgaard
Senior Vice President, California Health Plan Operations
Kaiser Foundation Health Plan, Inc., dba Kaiser Foundation, Permanente Medical Care Program
1950 Franklin Street, 20th Floor
Oakland, CA 94612

Re: Limitations or Exclusions of Abortion Services

Dear Mr. Overgaard:

It has come to the attention of the Department of Managed Health Care (DMHC) that some Kaiser Foundation Health Plan, Inc., dba Kaiser Foundation, Permanente Medical Care Program (Kaiser) contracts contain language that may discriminate against women by limiting or excluding coverage for termination of pregnancies. The DMHC has reviewed the relevant legal authorities and has concluded that it erroneously approved or did not object to such discriminatory language in some evidence of coverage (EOC) filings. The DMHC has performed a survey and has discovered that such language is present in EOCs for products covering a very small fraction of California health plan enrollees.

The purpose of this letter is to remind plans that the Knox-Keene Health Care Service Plan Act of 1975[1] (Knox Keene Act) requires the provision of basic health care services and the California Constitution prohibits health plans from discriminating against women who choose to terminate a pregnancy. Thus, all health plans must treat maternity services and legal abortion neutrally.

Exclusions and limitations are also incompatible with both the California Reproductive Privacy Act and multiple California judicial decisions that have unambiguously established under the California Constitution that every pregnant woman has the fundamental right to choose to either bear a child or to have a legal abortion.[2,3] A health plan is not required to cover abortions that would be unlawful under Health & Safety Code § 123468.

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[2] Consistent with 42 U.S.C. § 18054(a)(6), this letter shall not apply to a Multi-State Plan.
[3] Although health plans are required to cover legal abortions, no individual health care provider, religiously sponsored health carrier, or health care facility may be required by law or contract in any circumstance to participate in the provision of or payment for a specific service if they object to doing so for reason of conscience or religion. No person may be discriminated against in employment or professional privileges because of such objections.

Regardless of existing EOC language, effective as of the date of this letter, Kaiser must comply with California law with respect to the coverage of legal abortions.

Required Action

1. Kaiser must review all current health plan documents to ensure that they are compliant with the Knox-Keene Act with regard to legal abortion. This includes plan documents previously approved or not objected to by the DMHC.

   In regards to coverage for abortion services, the descriptors cited below are inconsistent with the Knox-Keene Act and the California Constitution. Kaiser must amend current health plan documents to remove discriminatory coverage exclusions and limitations. These limitations or exclusions include, but are not limited to, any exclusion of coverage for "voluntary" or "elective" abortions and/or any limitation of coverage to only "therapeutic" or "medically necessary" abortions. Kaiser may, consistent with the law, omit any mention of coverage for abortion services in health plan documents, as abortion is a basic health care service.

2. To demonstrate compliance, health plans are directed to file any revised relevant health plan documents (e.g. EOCs, subscriber documents, etc.) with the Department as an Amendment to the health plan's license within 90 days of the date of this letter. The filing should highlight as well as underline the changes to the text as required by the California Code of Regulations, title 28, §1300.52(d).

Authority Cited

California Constitution, article 1, section 1; Health and Safety Code §1340, et seq. and Health and Safety Code §123460 et seq., and implementing regulations.

If you have any questions concerning the guidance issued in this letter, please contact the Office of Plan Licensing reviewer.

Sincerely,

Michelle Rouillard

MICHELLE ROUILLARD
Director
Department of Managed Health Care

cc: Deborah Espinal, Executive Director of Policy, Kaiser Foundation Health Plan, Inc.

DEPARTMENT OF
Managed
Health Care

Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency

Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725
Phone: (916) 324-8176
Fax: (916) 255-5241

August 22, 2014

VIA ELECTRONIC MAIL & U.S. MAIL

Brandon Cuevas
UnitedHealthcare of California, President and CEO
UHC of California
5995 Plaza Drive
Cypress, CA 92630

Re: Limitations or Exclusions of Abortion Services

Dear Mr. Cuevas:

It has come to the attention of the Department of Managed Health Care (DMHC) that some UHC of California (UHC) contracts contain language that may discriminate against women by limiting or excluding coverage for termination of pregnancies. The DMHC has reviewed the relevant legal authorities and has concluded that it erroneously approved or did not object to such discriminatory language in some evidence of coverage (EOC) filings. The DMHC has performed a survey and has discovered that such language is present in EOCs for products covering a very small fraction of California health plan enrollees.

The purpose of this letter is to remind plans that the Knox-Keene Health Care Service Plan Act of 1975[1] (Knox Keene Act) requires the provision of basic health care services and the California Constitution prohibits health plans from discriminating against women who choose to terminate a pregnancy. Thus, all health plans must treat maternity services and legal abortion neutrally.

Exclusions and limitations are also incompatible with both the California Reproductive Privacy Act and multiple California judicial decisions that have unambiguously established under the California Constitution that every pregnant woman has the fundamental right to choose to either bear a child or to have a legal abortion.[2,3] A health plan is not required to cover abortions that would be unlawful under Health & Safety Code § 123468.

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[2] Consistent with 42 U.S.C. § 18054(a)(6), this letter shall not apply to a Multi-State Plan.
[3] Although health plans are required to cover legal abortions, no individual health care provider, religiously sponsored health carrier, or health care facility may be required by law or contract in any circumstance to participate in the provision of or payment for a specific service if they object to doing so for reason of conscience or religion. No person may be discriminated against in employment or professional privileges because of such objections.

Regardless of existing EOC language, effective as of the date of this letter, UHC must comply with California law with respect to the coverage of legal abortions.

Required Action

1. UHC must review all current health plan documents to ensure that they are compliant with the Knox-Keene Act with regard to legal abortion. This includes plan documents previously approved or not objected to by the DMHC.

   In regards to coverage for abortion services, the descriptors cited below are inconsistent with the Knox-Keene Act and the California Constitution. UHC must amend current health plan documents to remove discriminatory coverage exclusions and limitations. These limitations or exclusions include, but are not limited to, any exclusion of coverage for "voluntary" or "elective" abortions and/or any limitation of coverage to only "therapeutic" or "medically necessary" abortions. UHC may, consistent with the law, omit any mention of coverage for abortion services in health plan documents, as abortion is a basic health care service.

2. To demonstrate compliance, health plans are directed to file any revised relevant health plan documents (e.g. EOCs, subscriber documents, etc.) with the Department as an Amendment to the health plan's license within 90 days of the date of this letter. The filing should highlight as well as underline the changes to the text as required by the California Code of Regulations, title 28, §1300.52(d).

Authority Cited

California Constitution, article 1, section 1; Health and Safety Code §1340, et seq. and Health and Safety Code §123460 et seq., and implementing regulations.

If you have any questions concerning the guidance issued in this letter, please contact the Office of Plan Licensing reviewer.

Sincerely,

Michelle Rouillard

MICHELLE ROUILLARD
Director
Department of Managed Health Care

cc: Elizabeth Hays, Director, Regulatory Affairs, UHC of California

Regardless of existing EOC language, effective as of the date of this letter, Blue Cross must comply with California law with respect to the coverage of legal abortions.

Required Action

1. Blue Cross must review all current health plan documents to ensure that they are compliant with the Knox-Keene Act with regard to legal abortion. This includes plan documents previously approved or not objected to by the DMHC.

   In regards to coverage for abortion services, the descriptors cited below are inconsistent with the Knox-Keene Act and the California Constitution. Blue Cross must amend current health plan documents to remove discriminatory coverage exclusions and limitations. These limitations or exclusions include, but are not limited to, any exclusion of coverage for "voluntary" or "elective" abortions and/or any limitation of coverage to only "therapeutic" or "medically necessary" abortions. Blue Cross may, consistent with the law, omit any mention of coverage for abortion services in health plan documents, as abortion is a basic health care service.

2. To demonstrate compliance, health plans are directed to file any revised relevant health plan documents (e.g. EOCs, subscriber documents, etc.) with the Department as an Amendment to the health plan's license within 90 days of the date of this letter. The filing should highlight as well as underline the changes to the text as required by the California Code of Regulations, title 28, §1300.52(d).

Authority Cited

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If you have any questions concerning the guidance issued in this letter, please contact your Plan's Office of Plan Licensing reviewer.

Sincerely,

Michelle Rouillard

MICHELLE ROUILLARD
Director
Department of Managed Health Care

cc: Terry German, Associate General Counsel, Blue Cross of California

Exhibit 403

May 2011: National poll shows majority support healthcare conscience rights, conscience law

Highlights of *the polling company, inc.* Phone Survey of the American Public

On May 3, 2011, the Christian Medical Association and the Freedom2Care coalition released the results of a nationwide, scientific poll conducted April 29-May 1, 2011 by the polling company™, inc./ WomanTrend. Survey of 1000 American Adults, Field Dates: April 29-May 1, 2011, Margin of Error=±3.1.

1. **77%** of American adults surveyed said it is either "very" or "somewhat" important to them that **"**that healthcare professionals in the U.S. are **not forced to participate** in procedures or practices to which they have **moral objections**." **16%** said it is not important.

ALL		*PRO-CHOICE* (n=465)	*PRO-LIFE* (n=461)
77%	Total **important** (net)	68%	85%
52%	Very important	42%	64%
25%	Somewhat important	26%	21%
16%	Total **not important** (net)	24%	8%
8%	Not too important	11%	5%
8%	Not at all important	13%	3%
8%	Do not know/depends	8%	6%
1%	Refused	*	

2. **50%** of American adults surveyed "strongly" or "somewhat" support "a **law** under which federal agencies and other government bodies that receive federal funds could **not discriminate** against hospitals and health care professionals who **decline to participate in abortions**." **35%** opposed.

ALL		*PRO-CHOICE* (n=465)	*PRO-LIFE* (n=461)
50%	Total **support** (net)	45%	58%
29%	Strongly support	20%	40%
21%	Somewhat support	25%	18%
35%	Total **oppose** (net)	43%	32%
14%	Somewhat oppose	20%	10%
21%	Strongly oppose	23%	22%
7%	It depends/need more info.	7%	5%
7%	Do not know	6%	5%
1%	Refused	1%	1%

April, 2009: Two National Polls[1] Reveal Broad Support for Conscience Rights in Health Care

Highlights of *the polling company, inc.* Phone Survey of the American Public

39% Democrat • 33% Republican • 22% Independent

1. **88%** of American adults surveyed said it is either "very" or "somewhat" **important to them that they share a similar set of morals as their doctors**, nurses, and other healthcare providers.
2. **87%** of American adults surveyed believed it is important to "make sure that healthcare professionals in America are **not forced to participate** in procedures and practices to which they have moral objections."
3. Support for the conscience protection regulation (rule finalized Dec. 2008):
   - **63% support conscience protection regulation**
   - 28% oppose conscience protection regulation
4. Support for Obama administration proposal to eliminate the new conscience protection regulation:
   - 30% support Obama administration proposal
   - **62% oppose Obama administration proposal**
5. Likelihood of voting for current Member of Congress who supported eliminating the conscience rule:
   - 25% more likely to vote for Member who supported eliminating rule
   - **54% less likely to vote for Member who supported eliminating rule**
6. "In 2004 the Hyde-Weldon Amendment was passed. It ruled that taxpayer funds must not be used by governments and government-funded programs to discriminate against hospitals, health insurance plans, and healthcare professionals who decline to participate in abortions. Do you support or oppose this law?"
   - **58% support Hyde-Weldon Amendment**
   - 31% oppose Hyde-Weldon Amendment

Highlights of Online Survey of Faith-Based Professionals

2,865 faith-based healthcare professionals

1. **Over nine of ten** (91%) faith-based physicians agreed, "I would **rather stop practicing medicine** altogether than be forced to violate my conscience."
2. **32%** of faith-based healthcare professionals report having "been **pressured to refer a patient** for a procedure to which [they] had moral, ethical, or religious objections."
3. **39%** of faith-based healthcare professionals have "experienced pressure from or **discrimination by faculty** or administrators based on [their] moral, ethical, or religious beliefs"
4. **20%** of faith-based medical students say they are "**not pursuing a career in Obstetrics or Gynecology**" because of perceived discrimination and coercion in that field.

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[1] Results of both 2009 surveys released April 8. On behalf of the Christian Medical Association, the polling companyTM, inc./ WomanTrend conducted a nationwide survey of 800 American adults. Field Dates: March 23 -25, 2009. The overall margin of error for the survey is ± 3.5% at a 95% confidence interval. The polling companyTM, inc./ WomanTrend also conducted an online survey of members of faith-based organizations, fielded March 31, 2009 to April 3, 2009. It was completed by 2,298 members of the Christian Medical Association, 400 members of the Catholic Medical Association, 69 members of the Fellowship of Christian Physicians Assistants, 206 members of the Christian Pharmacists Fellowship International, and 8 members of Nurses Christian Fellowship. http://www.freedom2care.org/learn/page/surveys

Freedom2Care www.Freedom2Care.org and The Christian Medical Association www.cmda.org

April 2009 Phone Survey of the American Public

Americans of all characteristics and politics seek shared values with healthcare professionals.

Fully 88% of American adults surveyed said it is either "very" or "somewhat" important to them that they enjoy a similar set of morals as their doctors, nurses, and other healthcare providers. Intensity was strong, as 63% described this as "very" important while at the other end of the spectrum, just 6% said it is "not at all important," a ratio of more than 10-to-1.

Voters will punish politicians who fail to defend healthcare providers' conscience rights.

Finally, when asked how they would view their Member of Congress if he or she voted against conscience protection rights, 54% indicated they would be less likely to back their United States Representative. In fact, 36% said they would be much less likely, a figure three times greater than the 11 % who said they would be much more likely. Furthermore, 43% of respondents who said they voted for President Obama indicated that they would be less inclined to back a Member of Congress if he or she opposed conscience protection rights.

Healthcare providers' conscience protections are viewed as an inalienable right.

A sizable 87% of American adults surveyed believed it is important to "make sure that healthcare professionals in America are not forced to participate in procedures and practices to which they have moral objections." 65% of respondents considered it very essential. Also joining with these majorities were 95% of respondents who self-identified as "pro-life," 78% who considered themselves "pro-choice," 94% who voted for Senator McCain in November 2008 and 80% who cast a ballot for (now) President Obama.

Americans oppose forcing healthcare providers to act against their consciences...

A majority (57%) of American adults opposed regulations "that require medical professionals to perform or provide procedures to which they have moral or ethical objections." In contrast, 38% favored such rules. A full 40% strongly objected to the rules while just 19% strongly backed them. A majority of conservative Republicans (69%), moderate Republicans (69%), and conservative Democrats (59%), as well as the plurality of liberal/moderate Democrats (49%), joining together to reject policies to that require doctors and nurses to act against their personal moral code or value set.

...Support laws that protect them from doing so...

Without any names or political parties being mentioned, support for the new conscience protection rule outpaced opposition by a margin of more than 2-to-1 (63% vs. 28%). Intensity favored the rule, with 42% strongly backing it and 19% strongly rejecting it. Endorsements for the rule spanned demographic and political spectra, with majorities in all cohorts offering their support. In fact, even 56% of adults who said they voted for President Obama last fall and 60% of respondents who self-identified as "pro-choice" said they favor this two-month old conscience protection rule.

... And oppose any efforts to remove such rules.

Opposition to revocation of the conscience protection rule outpaced support by a margin of more than 2- to-1 (62% vs. 30%). Intensity favored retention of the rule (44% strongly opposing rescission versus 17% strongly supporting it). There was consistent demographic alignment and cohesiveness across political lines, as 52% of self-identified Democrats, 67% of self-identified Independents, and 73% of self- identified Republicans, as well as 50% of liberals, 65% of moderates, and 69% of conservatives also opposed nullification. A narrow majority (53%) of people who considered themselves to be "pro-choice" opposed rescission. Notably, a small number

(7%) were ambivalent or undecided, saying they did not know or lacked the information to render an opinion one way or the other.

Online Survey of Faith-Based Medical Professionals

1. Medical access will suffer if doctors are forced to act against their moral and ethical codes.

In the survey of 2,865 members of faith-based organizations, doctors and other medical professionals voiced their concerns that serious consequences could occur if doctors are forced to participate in or perform practices to which they have moral or ethical objections. Nearly three-quarters (74%) believed that elimination of the conscience protection could result in "fewer doctors practicing medicine," 66% predicted "decreased access to healthcare providers, services, and/or facilities for patients in low-income areas," 64% surmised "decreased access to healthcare providers, services, and/or facilities for patients in rural areas," and 58% hypothesized "fewer hospitals providing services."

Asked how rescission of the rule would affect them personally, 82% said it was either "very" or "somewhat" likely that they personally would limit the scope of their practice of medicine. This was true of 81% of medical professionals who practice in rural areas and 86% who work full-time serving poor and medically-underserved populations.

The conscience protection rule is fundamental and necessary in the medical profession.

Fully 97% of members who participated in the survey supported the two-month-old conscience protection clause and 96% objected to rescission of the rule. 91% of physicians agreed, "I would rather stop practicing medicine altogether than be forced to violate my conscience." The Department of Health and Human Services has asked whether the objectives of the conscience protection rule can be achieved "through non-regulatory means, such as outreach and education." Nearly nine-in-ten (87%) members surveyed – those who are on the ground, in hospitals and clinics across the country – felt "outreach and education" alone were insufficient to accomplish the goal. Ninety-two percent declared the codification of conscience protection to be necessary (83% "very" and 9% "somewhat") based on their knowledge of "discrimination in healthcare on the basis of conscience, religious, and moral values."

Discrimination is widespread in education and professional practice.

Asked to assess their educational experiences:

- 39% have "experienced pressure from or discrimination by faculty or administrators based on [their] moral, ethical, or religious beliefs"
- 33% have "considered not pursuing a career in a particular medical specialty because of attitudes prevalent in that specialty that is not considered tolerant of [their] moral, ethical or religious beliefs."
- 23% have "experienced discrimination during the medical school or residency application and interview process because of [their] moral, ethical or religious beliefs."

Asked to assess their professional experiences:

- 32% have "been pressured to refer a patient for a procedure to which [they] had moral, ethical, or religious objections."
- 26% have "been pressured to write a prescription for a medication to which [they] had moral, ethical, or religious objections."
- 17% have "been pressured to participate in training for a procedure to which [they] had moral, ethical, or religious objections."
- 12% have "been pressured to perform a procedure to which [they] had moral, ethical, or religious objections."

Discrimination is forcing faith-based medical students to shun careers in Obstetrics and Gynecology.

- 20% of students surveyed agreed with the statement, "I am **not pursuing a career in Obstetrics or Gynecology** mainly because I do not want to be forced to compromise my moral, ethical, or religious beliefs by being required to perform or participate in certain procedures or provide certain medications."
- **96%** of medical students support (90% "Strongly Support") the conscience protection regulation.
- 32% of medical students say they "have experienced pressure from or **discrimination by faculty** or administrators based on your moral, ethical, or religious beliefs."

Exhibit 404

TO: Interested Parties

FROM: Kellyanne Conway, President & CEO
the polling company™, inc./WomanTrend

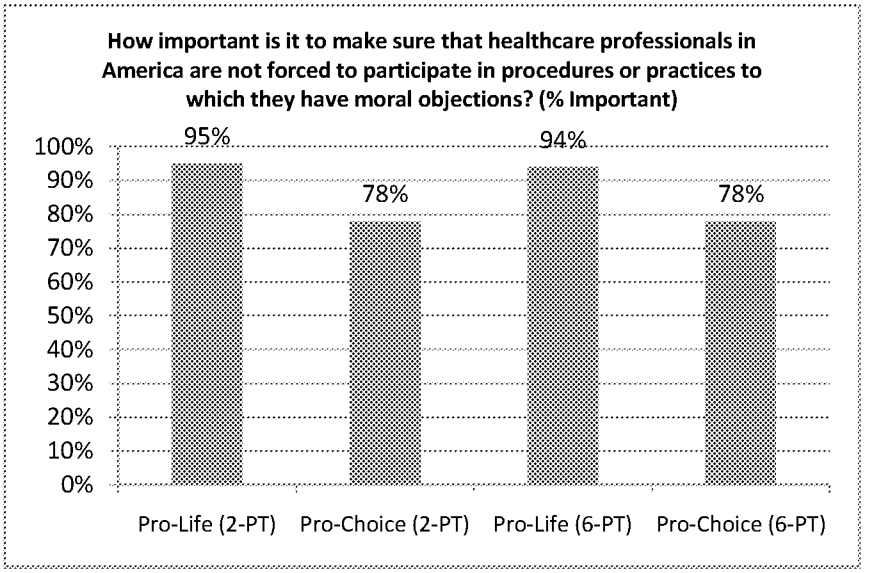
DATE: April 8, 2009

RE: Key Findings on Conscience Rights Polling

On behalf of the Christian Medical & Dental Association (CMDA), the polling company™, inc./ WomanTrend *conducted a nationwide survey of 800 American adults and an online survey of members of faith-based medical organizations. Full statements of methodology can be found at the conclusion of this document.*

Americans of All Demographic Characteristics and Political Stripes Seek a Shared a Set of Values with their Healthcare Providers.
Fully 88% of American adults surveyed said it is either "very" or "somewhat" important to them that they enjoy a similar set of morals as their doctors, nurses, and other healthcare providers. Intensity was strong, as 63% described this as "very" important while at the other end of the spectrum, just 6% said it is "not at all important," a ratio of more than 10-to-1.

Healthcare Providers' Conscience Protections Viewed as an Inalienable Right
A sizable 87% of American adults surveyed believed it is important to ***"make sure that healthcare professionals in America are not forced to participate in procedures and practices to which they have moral objections."*** Support for this protection garnered considerable intensity as well, with 65% of respondents considering it very essential. Majorities of men, women, and adults of all ages, races, regions, and political affiliations considered it critical to defend the rights of healthcare providers to refuse to perform certain procedures on moral grounds. Also joining with these majorities were 95% of respondents who self-identified as "pro-life," 78% who considered themselves "pro-choice," 94% who voted for Senator McCain in November 2008 and 80% who cast a ballot for (now) President Obama.



Americans Oppose The *Principle* of Forcing Healthcare Providers to Act Against Their Consciences...
A majority (57%) of American adults opposed regulations ***"that require medical professionals to perform or provide procedures to which they have moral or ethical objections."*** In contrast, 38% favored such rules. The potency of opposition was twice that of the supporters: 40% strongly objected to the laws while just 19% strongly backed them. Politically, a majority of conservative Republicans (69%), moderate Republicans (69%), and conservative Democrats (59%), as well as the plurality of liberal/moderate Democrats (49%), joining together to reject policies to that require doctors and nurses to act against their personal moral code or value set.

…Support Laws That Protect Them From Doing So…
Without any names or political parties being mentioned, respondents were provided with a short description of the new conscience protection law and its recent inception: ***"Just two months ago, a federal law known as 'conscience protection' went into effect after reports of doctors being discriminated against for declining to perform abortions. It protects doctors and other medical professionals who work at institutions that receive federal money from performing medical procedures to which they object on moral or religious grounds."***

After hearing this short description, support for this new law outpaced opposition by a margin of more than 2-to-1 (63% vs. 28%). Intensity favored the law, with 42% strongly backing it and 19% strongly rejecting it. Endorsements for the rule spanned demographic and political spectra, with majorities in all cohorts offering their support. **In fact, even 56% of adults who said they voted for President Obama last fall and 60% of respondents who self-identified as "pro-choice" said they favor this two-month old conscience protection rule.**

… And Oppose Any Efforts to Remove Such Laws.
Next, respondents were asked to react to the proposed rescission of the conscience protection law: *"Earlier this month, officials from the U.S. Department of Health and Human Services introduced a rule change that would effectively eliminate the two-month-old conscience protection. This could mean that doctors and other medical professionals could be coerced to participate in medical procedures to which they object on moral or religious grounds."*

Opposition to revocation of the conscience protection law outpaced support by a margin of more than 2-to-1 (62% vs. 30%). As was the case in the previous question, intensity favored retention of the law (44% strongly opposing rescission versus 17% strongly supporting it). Again, there was consistent demographic alignment, as a majority of men, women, and adults of all ages, races, incomes, regions, and geographic types stood together to reject removal of the law. And, there was cohesiveness across political lines, as 52% of self-identified Democrats, 67% of self-identified Independents, and 73% of self-identified Republicans, as well as 50% of liberals, 65% of moderates, and 69% of conservatives also opposed nullification. A narrow majority (53%) of people who considered themselves to be "pro-choice" opposed rescission. Notably, a small number (7%) were ambivalent or undecided, saying they did not know or lacked the information to render an opinion one way or the other.

Rescission of Conscience Protection Viewed by a Majority as Government Insinuating Itself into the Patient-Physician Relationship.
When asked whether rescission of the rule and a resulting forced participation of doctors in abortions is a sign of more, less, or the right amount of government involvement in medicine, the majority (58%) said it exemplified excessive participation. Just 18% thought it reflected the ideal role and 11% believed it was still too minimal.

The Political Currency Calculus: Voters Will Punish Politicians Who Fail to Defend Healthcare Providers' Rights to Refuse to Violate Their Conscience in the Name of Medicine.
Finally, when asked how they would view their Member of Congress if he or she voted ***against*** conscience protection rights, 54% indicated they would be less likely to back their United States Representative. In fact, 36% said they would be *much less likely*, a figure three times greater than the 11% who said they would be *much more likely*. Furthermore, 43% of respondents who said they voted for President Obama indicated that they would be less inclined to back a Member of Congress if he or she opposed conscience protection rights.

Rescission of Conscience Protections May be a Priority for Obama Administration, but not for his Constituents.
When presented with a list of 13 areas for the sitting Congress and current President to address and allowed to select multiple answers, only 10% of American adults preferred that Washington devote its time and energy to abortion policy. In fact, the issue of abortion was ranked 9th out of 13 among the issues offered to survey respondents. Moreover, adults desirous of action on abortion policy were six times more likely to be "pro-life" than "pro-choice" (19% vs. 3%). In contrast, no less than 68% of any demographic or political cohort studied said that President Obama and Congressional leaders should focus on the economy and jobs.

Real Effects Likely to Be Felt in Medical Community If Doctors Forced to Act Against Their Moral and Ethical Codes
In the survey of 2,865 members of faith-based organizations, doctors and other medical professionals voiced their concerns that serious consequences could occur if doctors are forced to participate in or perform practices to which they have moral or ethical objections. Nearly three-quarters (74%) believed that elimination of the conscience protection could result in "fewer doctors practicing medicine," 66% predicted "decreased access to healthcare providers, services, and/or facilities for patients in low-income areas," 64% surmised "decreased access to healthcare providers, services, and/or facilities for patients in rural areas," and 58% hypothesized "fewer hospitals providing services."

When asked how rescission of the conscience rule would affect them personally, fully 82% said it was either "very" or "somewhat" likely that they personally would limit the scope of their practice of medicine. This was true of 81% of medical professionals who practice mainly in rural areas and 86% who work full-time in serving poor and medically-underserved populations.

Conscience Protection Rule Fundamental and Necessary in the Medical Profession, According to Members of the Christian Medical & Dental Association, the Catholic Medical Association, and the Christian Pharmacists Fellowship International
Fully 97% of members who participated in the survey supported the two-month-old conscience protection clause and 96% objected to rescission of the rule.

The Department of Health and Human Services has asked whether the objectives of the conscience protection law can be achieved "through non-regulatory means, such as outreach and education." Nearly nine-in-ten (87%) members surveyed – those who are on the ground, in hospitals and clinics across the country – felt "outreach and education" alone were insufficient to accomplish the goal.

Ninety-two percent declared the codification of conscience protection to be necessary (83% "very" and 9% "somewhat") based on their knowledge of "discrimination in healthcare on the basis of conscience, religious, and moral values." Many respondents held this opinion due in part to their own personal experience. When asked to assess their educational experiences:

- 39% have "experience pressure from or discrimination by faculty or administrators based on [their] moral, ethical, or religious beliefs"
- 33% have "considered not pursuing a career in a particular medical specialty because of attitudes prevalent in that specialty that is not considered tolerant of [their] moral, ethical or religious beliefs."
- 23% have "experienced discrimination during the medical school or residency application and interview process because of [their] moral, ethical or religious beliefs."

And, when asked to assess their professional experiences:

- 32% have "been pressured to refer a patient for a procedure to which [they] had moral, ethical, or religious objections
- 26% have "been pressured to write a prescription for a medication to which [they] had moral, ethical, or religious objections
- 17% have "been pressured to participate in training for a procedure to which [they] had moral, ethical, or religious objections."
- 12% have "been pressured to perform a procedure to which you had moral, ethical, or religious objections."

STATEMENT OF METHODOLOGY

Nationwide Survey of Adults:
On behalf of the **Christian Medical & Dental Association,** the polling company™, inc./ WomanTrend conducted a nationwide survey of 800 American Adults (18+). The survey contained one screener question, 10 substantive questions, and 13 demographic inquiries. All substantive questions were closed-ended in nature.

The survey was fielded March 23-25, 2009 at a Computer-Assisted Telephone Interviewing (CATI) facility using live callers. The sample was drawn utilizing Random Digit Dial, a computer dialing technique that ensures that every household in the nation with a landline telephone has an equal chance of being called. Each respondent was screened to ensure he or she was 18 years of age.

Sampling controls were used to ensure that a proportional and representative number of people were interviewed from such demographic groups as age, race and ethnicity, and region according to the most recent figures available from the U.S. Census Bureau and voter registration and turnout figures. After data collection, weighting was used to ensure that the sample reflected the current population. This is a common and industry-accepted practice. Age, race, and gender were allowed four points of flexibility in pre-set quotas while three points of flexibility was permitted on region.

The overall margin of error for the survey is ± 3.5% at a 95% confidence interval, meaning that in 19 out of 20 cases, the data obtained would not differ by any more than 3.5 percentage points in either direction if the survey were repeated multiple times employing this methodology and sampling method. Margins of error for subgroups are higher.

Online Survey of Members of Faith-Based Medical Organizations:
On behalf of the **Christian Medical & Dental Association,** the polling company™, inc./ WomanTrend conducted an online survey of members of faith-based organizations. The Catholic Medical Association and Christian Pharmacists Fellowship International also invited their members to participate.

The survey was fielded March 31, 2009 to April 3, 2009 and was completed by 2,865 members of the Christian Medical and Dental Association (CMDA), 400 members of the Catholic Medical Association (CMA), 69 members of the Fellowship of Christian Physicians Assistants, 206 members of the Christian Pharmacists Fellowship International, and 8 members of Nurses Christian Fellowship. Respondents were allowed to select membership in multiple organizations.

Each respondent was provided with a unique hyperlink to take the survey, allowing no member to take the survey more than once and prohibiting respondents from passing the link to another individual after completing the survey.

This survey is intended to demonstrate the views and opinions of members surveyed. It is not intended to be representative of the entire medical profession nor of the entire membership rosters of these organizations. Respondents who participated in the survey were self-selecting.

Exhibit 405

NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

FACT SHEET

Health Care Refusals Harm Patients: The Threat to LGBT People and Individuals Living with HIV/AIDS

May 2014

Lesbian, gay, bisexual, and transgender (LGBT) individuals and individuals living with HIV/AIDS have long faced barriers to obtaining necessary health care. LGBT individuals have higher rates of uninsurance than their heterosexual counterparts, experience worse health outcomes, and often face discrimination in health care settings.[1] Additionally, LGBT individuals are at a higher risk for mental illness, cancer, and other diseases.[2] These disparities are only exacerbated when health care providers refuse to provide needed care because of personal or religious beliefs. Refusals to provide medically appropriate care can have serious emotional, physical, and financial consequences for patients.

Some proponents of refusals argue that patients can find an alternative provider, hospital, or clinic. However, this is often not the case – especially in emergency situations, rural areas, or long-term care facilities, where a refusal can simply leave a patient without access to necessary care. Moreover, this perspective obscures the ways refusals exacerbate stigma and discrimination already faced by LGBT people and individuals living with HIV/AIDS.

LGBT people and individuals living with HIV/AIDS report being denied care altogether or treated in a discriminatory manner.

- Studies have found LGBT individuals and people living with HIV/AIDS may be refused care or treated in a discriminatory manner because of their sexual orientation, gender identity, or HIV status. Approximately 8% of LGB individuals, nearly 27% of transgender and gender-nonconforming individuals, and almost 20% of HIV-positive individuals report being denied needed health care outright.[3]
- LGBT people and individuals living with HIV/AIDS report that health care professionals have used harsh language towards them, refused to touch them or used excessive precaution, or blamed the individuals for their health status.[4] The numbers are especially high for transgender and gender-nonconforming individuals, with over 20% reporting that they were subjected to harsh or abusive language by a health care professional and were blamed for their health problems.[5]
- Some LGBT individuals also report being excessively questioned about their sexuality or unnecessarily examined by health care providers even when their sexual orientation or gender identity was completely unrelated to the reason for their visit. For example, a participant in a recent study on LGBT health reported, "I went in for a broken hand and was grilled about my sexuality for ten minutes by the emergency room doctor. It was very frustrating and embarrassing because I felt like there must be something wrong, I'm not giving a good enough answer."[6] A transgender patient reported seeking treatment for a sore throat, and being "forced to have a pelvic exam." According to the patient, "The doctor invited others to look at me while he examined me and talked to them about my genitals."[7] Such unnecessary questioning and examination is discriminatory and harms patient care.

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Refusals to provide health services to LGBT people and individuals living with HIV/AIDS endanger patients' lives and health and can have irreversible consequences.[8]

- In one case, a 39-year old teacher allegedly died after not getting appropriate medical care due to her sexual orientation.[9] According to a lawsuit filed by her brother, the teacher's medical condition was not taken seriously by the EMTs who responded to her 911 call after they "'became immediately aware'" she was a lesbian. She was abandoned for over an hour after being admitted to the hospital – in violation of protocol – and while unattended, she fell into a coma.[10] She died several days later.[11]
- In another case, a 53-year old man in need of a kidney transplant was denied coverage by his insurance company because of his HIV-positive status, putting his life at risk.[12]
- An HIV-positive patient filed a lawsuit against his primary care physician, alleging that the doctor treated him "like an outcast" because of his HIV status and failed to provide the kind of care individuals without HIV received.[13] After the doctor refused to authorize emergency room treatment, the patient was brought to the ER by police and admitted to the hospital with internal bleeding; he was ultimately diagnosed with an infection, pneumonia, and AIDS.[14]
- A transgender woman was refused her prescription hormone medication while at state juvenile detention facilities. This denial led to "severe health consequences and emotional distress" due to withdrawal symptoms.[15]
- A patient with HIV who was admitted to a hospital reported that after he disclosed that he had sex with men, the hospital staff ignored him, refused to allow his family to visit, and did not honor his requests for his HIV medication.[16] The doctor at the hospital told the patient's personal doctor, "This is what he gets for going against God's will" and "You must be gay, too, if you're his doctor."[17] Despite explaining to the nurses the importance of taking his HIV medication, the patient missed five doses.[18] Because some HIV medications are highly time-sensitive, a missed or delayed dose can make the medicine less effective or even completely ineffective.

Refusals to provide health care to LGBT people and those living with HIV/AIDS can further traumatize patients who are already in physical and emotional distress.

- According to one transgender woman, a hospital refused to allow her doctor to perform breast-augmentation surgery at its facilities.[19] The outpatient surgery manager reportedly told the patient that the facilities could not be used for her surgery because "God made you a man."[20] The patient stated that this caused her to feel "shock, embarrassment, intimidation, physical distress and injury, humiliation, fear, [and] stress. . . ."[21]
- After two years of treatment for severe back pain, an orthopedic surgeon recommended spinal fusion surgery to his patient. Yet upon learning one week prior to surgery that the patient was HIV-positive, the surgeon canceled surgery and refused to perform it.[22] It took several months for the patient to find another surgeon and schedule the surgery. During that time, the patient suffered from severe physical pain and emotional distress.[23]
- A transgender man reported "living with excruciating pain in my ovaries because I can't find a doctor who will examine my reproductive organs."[24]
- Because of her objections to same-sex relationships, a counseling student refused to provide any counseling about relationship issues to a gay client suffering from depression.[25]

Refusals to provide health care to LGBT people and those living with HIV/AIDS add expenses and burdens to health care for those who can least afford it.

- LGBT and HIV-positive individuals in rural areas or who have inflexible jobs or low-incomes are especially harmed by refusals. The additional time and expense of finding an alternative provider after a refusal falls most heavily on them.[26] One provider who compassionately treats LBGT individuals reported that some of his patients travel more than 500 miles to receive routine care from him.[27]
- As those who are LGBT or living with HIV/AIDS age, they encounter discrimination and refusals in the long-term care setting.[28] LGBT elders and those living with HIV too often report being denied medical treatment at, abruptly discharged from, or denied admission to long-term care facilities.[29] In one case, six nursing homes refused to care for an HIV-positive man. The man's family was forced to place him in a facility 80 miles away from their home.[30]
- An infertility practice group accepted Guadalupe Benitez as a patient, and subjected her to a year of invasive tests and treatments.[31] When it became clear that she needed in vitro fertilization to become pregnant, every doctor in the practice refused, claiming that their religious beliefs prevented them from performing the procedure for a lesbian. This clinic was the only one covered by her health insurance plan, so Ms. Benitez had to pay for treatment at another clinic, despite having insurance coverage for infertility treatment.

Fear of discrimination prevents LGBT people and individuals living with HIV/AIDS from seeking needed medical care.

A refusal, or the fear of being refused care, can lead LGBT individuals and people living with HIV/AIDS to distrust health care workers and to feel alienated, ashamed, and vulnerable. This can discourage people from disclosing personal information that can be essential to their care or lead patients to avoid the health care system entirely or to delay necessary care.[32] Indeed, those most in need of services frequently report mistreatment by providers.[33]

- According to one transgender patient, "Finding doctors that will treat, will prescribe, and will even look at you like a human being rather than a thing has been problematic. [I have] been denied care by doctors and major hospitals so much that I now use only urgent care physician assistants, and I never reveal my gender history."[34]
- Nearly 30% of transgender individuals reported postponing or avoiding medical care when they were sick or injured, due to discrimination and disrespect, and over 30% delayed or did not try to get preventive care.[35]
- Over 1 in 5 LGBT individuals reported withholding information about their sexual practices from their doctor or another health care professional.[36]
- A main barrier to getting appropriately screened for breast cancer among lesbian women is poor communication with their health care providers, which one study found was due to fear of discrimination based on sexual orientation.[37]

Refusals to provide medically appropriate care violate ethical standards and anti-discrimination laws.

Proponents of refusals claim they are necessary to protect "religious freedom" or the personal beliefs of health

care workers. But personal or religious beliefs neither exempt health care workers from complying with anti-discrimination laws, including the anti-discrimination provisions of the federal health care law,[38] nor allow them to interfere with any patient's right to access medically appropriate care.

- Insurance issuers selling insurance in the new health insurance exchanges are prohibited from discriminating on the bases of gender identity and sexual orientation.[39]
- Hospitals that receive federal money are prohibited from restricting or denying patient visitation based on sexual orientation or gender identity.[40]
- Health provider organizations including the American Medical Association and American Counseling Association have made clear that providers and institutions that offer services to the public cannot deny those services to patients based on sexual orientation, gender identity, HIV status, or any discriminatory ground.[41]

Simply put, a health care worker should no more refuse to treat people because they are lesbian, gay, bisexual, transgender, gender non-conforming, or living with HIV/AIDS than because of their race or religion.

HEALTH CARE REFUSALS HARM PATIENTS: THE THREAT TO LGBT PEOPLE AND INDIVIDUALS LIVING WITH HIV/AIDS • FACT SHEET

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA et al,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C 19-02405 WHA
Related to
No. C 19-02769 WHA
No. C 19-02916 WHA

DECLARATION OF LOIS BACKUS, M.P.H., IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date:	October 30, 2019
Time:	8:00 AM
Dept:	12
Judge:	Hon. William H. Alsup
Trial Date:	None Set
Action Filed:	5/2/2019

I, Lois Backus, M.P.H., declare:

1. I am the Executive Director of Plaintiff Medical Students for Choice ("MSFC"). MSFC is 501(c)(3) non-profit that advocates for full integration of reproductive healthcare, including abortion and contraception, into the curricula at medical schools and residency programs. A copy of my curriculum vitae setting forth my experience, education, and credentials in greater detail is attached as Exhibit A.

2. MSFC is comprised of student-led chapters at medical schools, and these grass-root, student activists are supported by the national MSFC staff, who implement programming, manage resources, and provide expertise. Medical student activists make up the majority of our Board of Directors, and the MSFC student chapters provide data and information about the state of family planning training at the local-level to guide the strategic planning of the Board.

3. MSFC's central mission is to expand access to health services that allow patients to lead safe, healthy lives consistent with their own personal and cultural values, including with respect to all aspects of sexual and reproductive health. MSFC furthers this mission by supporting future generations of family planning providers in accessing training in abortion and contraception.

4. MSFC has 163 chapters in 45 U.S. states, and another 55 chapters outside of the U.S. We have thousands of current student members across the nation.

5. I submit this Declaration in support of Plaintiffs' challenge to the final rule promulgated by the Department of Health and Human Services ("HHS") relating to "Conscience Rights in Health Care" (the "Rule").

6. Despite this considerable number of students desiring family planning training and the commonality, simplicity, and safety of outpatient abortion,[1] most medical students do not receive training in abortion, and some do not even receive training in contraceptive care. Less than half of our members learned about first-trimester abortion from their schools.

[1] National Academies of Science, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States* 77 (2018) ("The clinical evidence makes clear that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective.").

7. When future doctors are not educated about abortion and family planning, they are unable to offer their patients the full range of reproductive healthcare.

8. Reproductive choice is only a reality for patients when there are enough family planning providers available to meet patients' needs and such providers are geographically accessible and available in an equitable distribution. Presently, the supply of such providers is not meeting the needs of American patients, in large part because facilities providing abortion are increasingly concentrated in cities, and very few primary care providers are skilled in family planning despite the continuity of care they could offer to patients, especially outside of urban areas.[2] Only a very small number of privately practicing OB/GYNs provide abortion in their practice, and one survey found that 35% of physicians who do not provide abortion do not refer for it either.[3] As threats to abortion training programs increase, this gap widens, further constraining abortion access for patients.[4]

9. Medical schools and residency programs receive substantial funding from HHS. Teaching hospitals receive a significant majority of their training budgets from HHS. In total, HHS provides over $10 billion per year directly and indirectly to teaching hospitals through Medicare, Medicaid, and other funding streams.[5] In 2018, 45 of the 50 top National Institutes of Health grant amounts were to teaching hospitals and medical education programs.[6] Residency programs are directly subsidized by federal programs—residents receive salaries from Medicare funding, and residency programs bill to Medicare for the services of their residents.

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[2] *See* Susan Yanow, *It Is Time to Integrate Abortion into Primary Care*, 103(1) Am. J. of Pub. Health 14 (2013).

[3] Desai S et al., *Estimating Abortion Provision and Abortion Referrals Among United States Obstetrician-Gynecologists in Private Practice*, 97(4) Contraception 297 (2018).

[4] *See* Jones RK & Jerman J, *Abortion Incidence and Service Availability In the United States, 2014*, 49(1) Persp. on Sexual & Reprod. Health 17 (2017).

[5] Elayne J. Heisler et al., *Federal Support for Graduate Medical Education: An Overview*, Congressional Research Service (Dec. 27, 2018), https://fas.org/sgp/crs/misc/R44376.pdf.

[6] Alex Philippidis, *Top 50 NIH-Funded Institutions of 2018*, Genetic Engineering & Biotechnology News (June 4, 2018), https://www.genengnews.com/a-lists/top-50-nih-funded-institutions-of-2018.

10. I understand that teaching hospitals and residency programs are considered "direct recipients" under the Rule. All of the institutions and programs currently training our student members must immediately comply with the Rule if it goes into effect. Moreover, to the extent that medical students and residents are considered subrecipients under the Rule, a teaching facility may also bear responsibility for the compliance of their students or residents.

11. MSFC fears that the Rule will significantly incentivize the limited number of remaining programs training students and residents in abortion and contraception to discontinue family planning training. MSFC justifiably fears further and extensive reduction in training programs because it has already become aware of extensive threats to such training even prior to the promulgation of the Rule, and the Rule will provide extremely strong incentives for the remaining providers to turn away abortion patients.

12. The national MSFC staff works to guide its student chapters on how to acquire training in family planning and avoid pitfalls imposed by certain institutions or legal requirements constraining access to such training. We monitor the state of abortion and contraception access across the country closely so we can effectively advise our chapters, and we receive data and information about access to abortion training across the 45 states in which our chapters operate.

13. Even when individual students and residents are willing to be trained in abortion care and contraception, and providers are willing to provide such education and services, their institutions may restrict the services they can learn and provide on the basis of religious or moral objection. These objections have already resulted in a severe reduction in the provision of family planning services.

14. For example, four of the ten largest healthcare systems in the United States by hospital count are now religiously-sponsored, a circumstance attributable in part to massive hospital consolidations between Catholic systems and secular institutions. Catholic hospitals now

care for approximately 1 in every 6 hospital patients in the U.S.[7] These hundreds of hospital consolidations have led many facilities to sacrifice family planning services.[8]

15. That is because religiously-affiliated institutions often have guidelines that prevent them from providing comprehensive reproductive healthcare. For example, the U.S. Conference of Catholic Bishops has issued *The Ethical and Religious Directives for Catholic Health Care* Services, which governs all Catholic health institutions and must be adopted by any hospital wishing to merge with a Catholic facility.[9] The *Directives* forbid doctors working in Catholic hospitals from all abortion and contraception procedures and counseling, except "natural family planning."[10] Aside from the direct prohibition on abortion and contraception, the *Directives* significantly restrict postpartum and direct sterilization, including tubal ligation and hysterectomy, elimination of ectopic pregnancy, medical miscarriage management or other fetal loss, screening for fetal anomalies, assisted reproductive technologies like IVF, and HIV and STI prevention counseling.[11] For example, following the merger of Swedish Medical Center ("Swedish") with Providence Health in 2012, the family medicine residency program at Swedish lost access to abortion training, and those residents have had to travel to other states to obtain it. The purchase of the Los Angeles County/University of Southern California family medicine program by Dignity Health in 2012 (formerly known as Catholic Healthcare West) resulted in a

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[7] Lois Uttley & Christine Khaikin, *Growth of Catholic Hospitals and Health Systems: 2016 Update of the Miscarriage Of Medicine Report*, MergerWatch 1 (2016), http://static1.1.sqspcdn.com/static/f/816571/27061007/1465224862580/MW_Update-2016-MiscarrOfMedicine-report.pdf?token=XlfagUpjX2g9GXDKAyqHQHDUbig%3D.

[8] *See id.*

[9] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (6th ed. 2018).

[10] *Id.* at 19.

[11] *See id.* at 18-19; *see also* Uttley & Khaikin, *supra* note 7, at 1 ("Catholic hospitals operate under ethical directives that prohibit the provision of key reproductive health services (such as contraception, abortion, sterilization and infertility services). We documented instances in which, as a result of these directives, women suffering reproductive health emergencies — including miscarriages — have been denied prompt, appropriate treatment at Catholic hospitals." (citing United States Conference of Catholic Bishops, *supra* note 9)).

ban on abortion training and counseling as well as a prohibition on prescribing birth control for all residents.

16. As a result of these mergers and other factors, it is already the case that huge regions of the country in the South and Midwest of the U.S. have deserts of abortion training where no hospitals or training programs offer abortion or contraception training.[12] This compounds the existing gaps in abortion and contraception access by preventing locally-training physicians from becoming skilled in providing family planning services.

17. In such areas, most of the limited opportunities to acquire training in family planning are offered by independent abortion clinics and Planned Parenthood affiliates. But, these facilities are themselves under tremendous strain from state restrictions in the South and Midwest.[13] And some states, including Oklahoma, require medical students to receive training at public hospitals, none of which provide family planning training.

18. There is no place in the country, however, that is not already experiencing threats to abortion training accessibility based on objections to care.[14] We expect that many hospitals that have not already bowed to the pressure from other institutions, members of their own leadership or staff, and/or political controversy to restrict or cease the provision of abortion and contraception, will quickly self-police and cease offering these services in order avoid the possibility of failing to comply with the Rule's vague and unworkable requirements. Further, we expect this self-regulation to take place not only in the South and Midwest, but in regions of the United States where access to reproductive healthcare is often assumed to be untouchable.

19. Several institutions have already bowed to this pressure, demonstrating the likelihood that the Rule will lead many other institutions to self-regulate. For example, the MSFC staff has spent two years working with a medical student at a major New York medical school. In 2008, this medical school simply eliminated all abortion information from the medical education

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[12] *See* Cartwright AF et al., *Identifying National Availability of Abortion Care and Distance From Major US Cities: Systematic Online Search*, 20(5) J. of Med. Internet Res. e186 (2018).

[13] *See id.*

[14] *See id.*

curriculum because of the religious concern of a major donor who sat on the Board of the over-arching health system. Since 2017, we have been assisting with producing a proposal to reimplement reproductive healthcare education for medical students at that institution. When asked by an MSFC resident, the medical students indicated that they thought the exclusion of abortion care was normal for American medical schools.

20. Also in New York state, an MSFC alumni treated a patient who was refused service at an emergency room while she was having a pre-viability miscarriage because a fetal heartbeat could still be detected. Although prior to viability, a completion of miscarriage procedure is the standard of care in such circumstances, individuals and institutions with religious and moral objections to abortion often treat these cases as abortion cases. She travelled to another provider, and the hospital and providers who ultimately received the patient further put her in jeopardy when the only anesthesiologist available refused to participate in the completion of miscarriage procedure, even as the patient had begun to hemorrhage.

21. At another major university in the Midwest, the family medicine residency program shut down the abortion training portion of their residency program because they were unwilling to risk the loss of any funding pursuant to a funding restriction that prohibited state funding for training on abortion that was passed in that state. The OB/GYN residency program, which was under separate leadership, elected to use other streams of funding to support their abortion training. Because of that, at that institution, depending on your residency program, even in the overall area of family or reproductive health, you may or may not have access to institutional abortion training due to distinctions in leadership within an overarching structure.

22. At another major east coast university medical school, students can rotate through a clinic for the homeless. Physicians who supervise the rotation are outspoken and anti-choice. As a result, MSFC members who performed the rotation were unable to even counsel patients about contraception because the supervising physicians informed the students that such care was "upsetting" to them (the physicians).

23. Teaching hospitals—defined as any hospital that provides any training to residents or medical students—are the vast majority of hospitals in the United States. Many training

programs also place students at other hospitals in their area. For example, another large medical school sends residents to 5 hospitals. One of these is a Catholic hospital. Based arbitrarily on where they are placed, therefore, residents may not be exposed at all to reproductive healthcare.

24. Catholic hospitals are also not the only religiously-affiliated hospitals that fail to provide reproductive healthcare. Other religiously-affiliated healthcare providers, including Adventist hospitals, do not provide such services.[15]

25. A medical school in Seattle ceased its abortion training due to the adoption of the *Ethical and Religious Directives* and began sending residents to Colorado to receive that training. This imposed significant cost on the program. When Colorado ceased providing training, the program began to send residents to Hawai'i for training at an even greater cost. Few programs will be this committed to training in abortion care.

26. We are familiar with numerous other instances of providers referring to our alumni because they were not allowed to provide the abortion care or contraceptive care needed by a patient at their institution. Even patients seeking to terminate wanted pregnancies due to fetal anomalies or experiencing miscarriage struggle to obtain care if they come across a provider who either refuses to assist or refuses even to provide them with a referral or any other kind of information.

27. Recently, an MSFC alumnus was called in to perform a therapeutic abortion in the second trimester for a patient whose life was endangered by her pregnancy. The hospital treating the patient did not have any trained physicians, and had to bring in an outside physician at considerable expense. These types of costs are also typically passed onto the patient.

28. To the extent that the Rule forces an institution of medical education to comply with onerous and unworkable rules at the risk losing the majority of its funding, we believe that many facilities will simply remove abortion and contraception from their curricula. There are numerous individuals involved in patient care at a major hospital—those responsible for

[15] Amy Littlefield, *Meet Another Religious Health System Restricting Reproductive Care*, Rewire (Jan. 30, 2019), https://rewire.news/article/2019/01/30/meet-another-religious-health-system-restricting-reproductive-health-care.

scheduling, cleaning, testing—all before you get to the medical staff. If, under the Rule, all of these people are empowered to delay or deny care or information related to abortion or contraception based on their own beliefs, and the hospital is powerless to intervene without risking loss of all federal funding, the Rule will impose innumerable harms on both patients and healthcare facilities. Rather than risk the loss of funding or an ethical and malpractice crisis related to patients denied and delayed access to care, even in an emergency, many facilities will self-regulate and eliminate contraceptive and abortion services.

29. Aside from the loss of training opportunities for our student and resident members, such a reduction in access to abortion and contraception training will impose significant harm on MSFC as whole by placing even greater strains on our already thinly stretched resources, which even today are insufficient to train all those who need such training outside of their institutions.

30. MSFC alumni are among the shrinking pool of abortion providers across 42 states. These alumni are the primary faculty at our educational programs. We have two sets of programs that we operate for our members who cannot acquire abortion training at their home institutions.

31. First, we run educational seminars that offer intensive education on family planning over several days. We can accept fewer than 500 students a year based on our current budget. This intensive education gives students a full picture of family planning as well as the social and political barriers they may face when seeking to become abortion providers. We also provide abortion training institutes for smaller groups of students. Acceptance to these institutes is competitive. We can accept fewer than 50% of those who apply.

32. Second, we run externship programs through independent clinics and Planned Parenthood affiliates. With the help of these strong allies, we are able to give some of our members a view into the day-to-day provision of care. Our members report that their externship is mind-opening—not because abortion is controversial—but precisely because of how simple and safe the procedure actually is. Members also have an opportunity to hear the stories of patients seeking abortion first-hand. This externship program is more difficult for residents, as compared with medical students, because they are insured through their training institution's malpractice program, and they must have approval to participate in the program. Residents also have less

flexibility in their schedule, and those that are able to take advantage of the program typically do so on vacation or during off-hours.

33. Further complicating the program, the number of clinics providing abortion care is dwindling. According to the most recent data from 2014, the number of facilities in the United States that held themselves out as providers of abortion care on a regular basis has markedly decreased.[16] Almost 90% of counties in the United States do not have an abortion clinic at all,[17] and several states have only one clinic left in the entire state.[18]

34. We financially assist students and residents participating in our training. We typically expend $1,000 to $2,000 per student or resident. These monies are spent on travel, accommodations, administrative fees, and any temporary licensing fees for receiving medical training outside a participant's home state. In total, we are currently spending in excess of $100,000 annually on these expenses, a substantial amount of money for our organization. We anticipate that the Rule could at least double the amount of money we need to spend, and therefore raise, in order to meet the anticipated increase in demand for training opportunities.

35. Although MSFC offers a number of training programs, the existing programs already are unable to meet the need.

36. Starting about ten years ago, MSFC began monitoring the impact of efforts to protect individual conscience at the expense of abortion training and patients' access to abortion. MSFC is part of a coalition of groups, including Catholics for Choice and various LGBTQ organizations, that focuses on religious refusals and "conscience rights" around the country. We stay in close contact with this coalition, so we can stay abreast of removals of abortion training and other threats to abortion access at teaching facilities across the country. MSFC has started to

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[16] The number of U.S. abortion-providing facilities declined 3% between 2011 and 2014 (from 1,720 to 1,671). Jones & Jerman, *supra* note 4. The number of clinics providing abortion services declined 6% over this period (from 839 to 788). *Id.*

[17] *Id.*

[18] *Bad Medicine: How a Political Agenda is Undermining Abortion Care and Access*, National Partnership for Women & Families (Mar. 2018), http://www.nationalpartnership.org/research-library/repro/bad-medicine-third-edition.pdf.

train students and residents on the impact of religious and moral refusals in the provision of family planning as well.

37. I have been in reproductive and community healthcare in some form my whole career. I completed a Master of Public Health at Yale, and I spent many years as the Executive Director of Planned Parenthood affiliates.

38. To the extent that the Rule enables almost any hospital staff-person, including some non-medical staff, to refuse to take any action related to an abortion, contraception, or other objected-to care, even in an emergency and without informing the patient, it is the broadest expansion of "conscience rights" that I and MSFC generally have seen or could have anticipated. Were it to take effect, the Rule would be impossible for a hospital to practically implement. Hospitals that provide abortion or have provided abortion already struggle to maintain patient care with medical staff refusing to assist with patients in need of care, as described above.

39. If the Rule goes into effect, the U.S. will see an even more dramatic reduction in the already dwindling number of medical-education institutions where abortion is regularly provided and taught to students and residents. Family planning training in the U.S. is already suffering; and the Rule will immeasurably exacerbate the problem.

40. MSFC would have to try to bridge the gap for highly motivated students. This would mean educating thousands of students a year. There will be many students who we cannot accommodate, and likely many more who will simply give up.

41. We already exist in a national medical system in which most licensed family medicine doctors and OB/GYNs are completely ignorant of both abortion, one of the most common and extremely safe reproductive procedures for women, and many forms of contraceptive counseling.

42. At MSFC, we believe that licensed physicians have an obligation to serve the needs of their patients. This means that physicians who object to providing care must ensure that their objection does not inhibit the patient from ultimately getting the care that they need in a timely manner. When a provider's personal beliefs conflict with a patient's need for care, medical ethics as well as state and federal law require the needs of the patient to take precedence. Within

the medical community, this bedrock principle is clear and well-accepted *outside of the provision of abortion care*, but compromised with respect to family planning, despite the opinions of major medical organizations that this ethical principle is particularly essential in reproductive healthcare.[19]

43. If this Rule goes into effect, abortion may simply fall out of mainstream medical education, and once a medical practice is removed, it may take years to reintroduce it into a complex hospital system.

44. Anti-abortion laws and campaigns have heavily stigmatized abortion and contraception,[20] and the professionals who providers these services.[21] Already, our students face incredible stigma when they relate their interest in becoming abortion providers. In many cases, once a physician has "outed" themselves as an abortion provider, they become isolated from the mainstream.

45. This Rule institutionalizes this isolation and will make it impossible even for many highly motivated MSFC members to acquire training. The result, should the Rule go into effect, will be compromised access to reproductive healthcare and staggering health consequences for patients across the nation.

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

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[19] *See, e.g.*, American College of Obstetricians and Gynecologists Committee on Ethics, *Committee Opinion No. 385: The Limits of Conscientious Refusal in Reproductive Medicine*, 110 Obstetrics & Gynecology 1203 (2007) ("Physicians and other health care providers have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that patients request."); American Medical Association, *Code of Medical Ethics Opinion 1.1.7: Physician Exercise of Conscience*, Ethics, https://www.ama-assn.org/delivering-care/physician-exercise-conscience (last visited June 6, 2019) ("In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer.").

[20] *See* Norris A et al., *Abortion stigma: a reconceptualization of constituents, causes, and consequences*, 21(3 Suppl) Women's Health Issues S49 (2011); Smith W et al., *Social Norms and Stigma Regarding Unintended Pregnancy and Pregnancy Decisions: A Qualitative Study of Young Women in Alabama*, 48(2) Persp. on Sexual & Reprod. Health 73 (2016).

[21] *See* Norris, *supra* note 20; Freedman L et al., *Obstacles to the integration of abortion into obstetrics and gynecology practice*, 41(3) Persp. on Sexual & Reprod. Health 146 (2010).

Executed on 8-29-19 in Philadelphia, Pennsylvania

Lois Backus

Lois Backus, M.P.H.
Executive Director, Medical Students for Choice

EXHIBIT A

Lois V. Backus, M.P.H.

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Lois V. Backus, MPH has been a non-profit chief executive in the reproductive health field for 30 years, with more than 17 years as the leader of Medical Students for Choice, an organization supporting the education and training of medical students in abortion.

Executive Experience -- 1989 through Today

2001 to present **Medical Students for Choice** Philadelphia, PA

Executive Director, responsible for leading an international, grassroots organization of more than 10,000 medical student activists worldwide who are working to make family planning a standard part of medical education and training. Primary programs include supporting 163 medical school chapters in the US and 60 chapters in 24 other countries with educational materials, funding, and training conferences in the US.

- Developed training conferences focusing on filling gaps in medical curricula pertaining to abortion, including the annual Conference on Family Planning and the Abortion Training Institutes. These training programs serve more than 500 US medical students each year.
- Expanded the Reproductive Health Externship Funding Program which places medical students in abortion-providing facilities for an intensive 2 to 4 week educational experience. This program serves between 180 and 200 medical students per year.
- Sustained and expanded MSFC's chapters from 96 to over 200 chapters.

1996-2001 **Planned Parenthood of the Columbia/Willamette** Portland, OR

Executive Director, responsible for all aspects of a 115 employee non-profit women's health and advocacy organization, with headquarters and six satellite facilities across Oregon and southwest Washington.

- Expanded the services provided in the flagship clinic to include reproductive surgeries for both men and women.
- Worked closely in collaboration with other social justice organizations to successfully fight ballot measures that would have hindered vital access to health services.
- Developed local community groups to support the expansion of government subsidized family planning services for the underserved in rural communities across Oregon.
- Opened three new facilities providing abortions, including establishing the first independent, comprehensive women's health clinic in central Oregon.

1989-1996 **Planned Parenthood of Central Pennsylvania** York, PA

Executive Director, responsible for leading a non-profit women's health organization serving York County, Pennsylvania. During these seven years, nine new services were added, including abortion services.

Education

M.P.H., Yale University School of Medicine, Department of Public Health, New Haven, CT.
A.B., Political Science and Religion, Mount Holyoke College, South Hadley, MA.

Other Relevant Experience

1988-1989 **Toltzis Communications** Glenside, PA
Project Manager Developed healthcare communications solutions for a marketing firm serving the pharmaceutical industry.

1987-1988 **Abington Memorial Hospital** Abington, PA
Coordinator, Community Health Education Provided medical screening and health education to a community of 100,000 people, including planning and implementing large community events.

1985-1987 **People's Medical Society** Emmaus, PA
Director of Policy Affairs Managed a nationwide grassroots organizing project focused on health care access for seniors.

1983-1984 **Community Treatment Complex** Worcester, MA
Program Coordinator Managed a residential treatment program for emotionally disturbed adolescents.

1980-1982 **Centers for Disease Control** Nashville, TN
Public Health Advisor Coordinated a federal sexually transmitted disease tracking program.

1978-1979 **Peace Corps** Kabul, Afghanistan
Volunteer Teacher Taught English and Business Mathematics to vocational college students.

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA et al,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C 19-02405 WHA
Related to
No. C 19-02769 WHA
No. C 19-02916 WHA

DECLARATION OF ELIZABETH BARNES IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date:	October 30, 2019
Time:	8:00 AM
Dept:	12
Judge:	Hon. William H. Alsup
Trial Date:	None Set
Action Filed:	5/2/2019

I, Elizabeth Barnes, declare:

1. I am the President of The Women's Centers, a group of reproductive healthcare clinics in the Northeast of the United States that provides abortion care and contraception, among other services.

2. The Hartford Gyn Center in Hartford, Connecticut is one such clinic. It opened in 1978, and is the only independent, state-licensed family-planning clinic in the State of Connecticut. The clinic also operates a medical residency rotation program.

3. I submit this Declaration in support of Plaintiffs' challenge to the final rule promulgated by the Department of Health and Human Services ("HHS") relating to "Conscience Rights in Health Care" (the "Rule") and the Rule's enforcement by the HHS Office of Civil Rights ("OCR").

4. Hartford Gyn's mission is to provide women with compassionate abortion care. We provide abortion through 21 weeks of pregnancy as well as other reproductive health services. In carrying out this mission, the autonomy of each patient is paramount. The clinic's practices are designed to support patients in making their own healthcare decisions free from external judgment. The clinic also advocates for the reproductive rights of all patients and seeks to effect corresponding social change.

5. Hartford Gyn is a subrecipient of federal Medicaid funding through the state of Connecticut. I understand that, as a result, Hartford Gyn will be considered a "subrecipient" under the Rule.

6. Connecticut is one of the states that permits the use of state Medicaid funding for elective abortions, with this funding separated from federal dollars also flowing through the state program, which can be used to reimburse non-abortion services.

7. In 2017, Medicaid funding accounted for 70 % of Hartford Gyn's income. Private insurance covered only 17 %, and cash payment and donations from abortion funds made up the remaining 13 %. While the clinic has not yet finalized these figures for 2018, they will remain at approximately these levels.

8. Abortion services accounted for 66 % of Hartford Gyn's services in 2017. The

remaining 34 % included contraception and a small amount of gynecological care. Although federal Medicaid dollars do not cover our abortion services, approximately half of the reimbursement we receive for our contraception and gynecological services originates with HHS.

9. Hartford Gyn's survival depends on the receipt of Medicaid funding, in part, because it receives so few patients who pay for their services privately or are covered by private insurance. Given the number of hospital facilities and individual physicians who provide gynecologic services in Connecticut for privately-paying patients, and the fact that the state Medicaid program reimburses providers for abortions and other services, it is impossible that Hartford Gyn would ever be able to rely on privately-paying patients to make up for the loss of federal Medicaid dollars. Reimbursement for gynecological services, a small percentage of our services, would also be insufficient to make up for the loss of federal Medicaid funding. At present, the clinic is barely sustained by the income generated by its current patient population. We exist, not for economic gain, but to pursue our mission of serving women in need of reproductive healthcare, including abortion and contraception.

10. Hartford Gyn would close quickly if it could not receive even a small percentage of its current income and would certainly close if we lost the sizable reimbursement we receive for contraception services. The clinic has no reserve funding, and clawback of any amount would bankrupt the business.

11. To the extent that the Rule prevents the clinic from expecting that staff members interact with all patients without judgment, would permit staff to unilaterally deny patients care and information, or force us to forego our emergency services and staffing practices, it is contrary to our mission and unworkable.

12. If it takes effect, the Rule will impose immediate administrative costs. Under the Rule, the clinic must maintain records of its compliance, although the Rule does not specify the exact form of these records.

13. The clinic will also be subject to investigation or inspection, measures which can be initiated unilaterally by HHS based on a complaint or even in the absence of a complaint. The Rule is silent as to whether HHS must inform the clinic of an investigation or follow any

particular procedure with respect to these investigations or inspections. The Clinic must cooperate with these measures; although the Rule is also silent as to the specific requirements of such cooperation. Further, the Rule states that HHS "shall" inspect any clinic based on any complaint or other information indicating an actual, possible, or threatened violation of the Rule. The Rule specifies that patient privacy is not grounds for denying access to records, even, apparently, patients' unredacted medical records.

14. If OCR finds a violation of the Rule, with or without a complaint, OCR is empowered to withdraw or even clawback our Medicaid funding. I understand that under the Rule, Connecticut's Medicaid program as the direct recipient also bears primary responsibility for our compliance with the Rule, incentivizing the state to fund less reproductive healthcare out of fear that the state might lose its federal funding. I further understand that under the Rule, the conduct or activity of contractors is "attributable" to the state for the purposes of enforcement or liability under the Weldon Amendment, further disincentivizing continued funding to the clinic. Loss of funding would shutter the clinic.

15. Hartford Gyn is unique even among clinics in progressive states for a number of reasons that would make its closure extremely burdensome for patients and providers.

16. First, Hartford Gyn has a broad depth of physician experience and provides advanced care, including abortion through 21 weeks of pregnancy, not provided by other facilities in the area. The clinic also employs a certified nurse-anesthetist, a specialized nurse that is rare and expensive. Hartford Gyn is the only independent abortion provider in Connecticut and the only non-hospital provider offering abortion care services past 19 weeks of pregnancy. Although hospital services may be available at some facilities, high cost and limited appointment availability can push this care out of reach for many people.

17. Second, Hartford Gyn sees patients from all walks of life, including low-income patients who cannot easily access care elsewhere, if at all. Hartford Gyn serves a large number of low-income patients, many of whom rely on Medicaid insurance, funding support, and/or discounted services at the clinic to access care. Further, many of Hartford Gyn's patients often face difficulties taking time from work, coordinating affordable transportation, and accessing

childcare—additional barriers to healthcare access. If Hartford Gyn were forced to close, patients who rely on the clinic for care will be forced to travel further the access care, compounding the logistical and financial challenges they face in accessing care, and preventing some from accessing care altogether, with disproportionate impacts on low-income patients.

18. Third, Hartford Gyn is one of the only facilities in the region that trains physicians in abortion care, especially in the second trimester. Although it does not receive significant outside funding for this training, it provides this service based on its deep commitment to supporting the next generation of providers. Currently, residents at Saint Francis Hospital and Medical Center can receive training from our medical director on Saturdays.

19. Fourth, Hartford Gyn has taken a public stance defending reproductive rights, including in media coverage of the clinic after a "crisis pregnancy center" opened just 30 feet from our office, in the same complex, and our clinic painted a "yellow brick road" for patients to follow when entering the clinic. The clinic is a symbol of the determined provision of constitutionally-protected care in the face of adversity for the reproductive rights movement, and, correspondingly, a known target of anti-abortion activists.

20. Anti-choice protestors target our clinic regularly. They have intimidated and threatened providers and patients at Hartford Gyn, and have misinformed and shamed our patients right outside of our clinic. Staff routinely enter the facility briskly out of fear the anti-choice protestors on the sidewalk or in our courtyard will photograph them, track their vehicle, or cause violence, and some staff have even been targeted at their homes. Further, according to data collected by the Feminist Majority Foundation, clinics located near a crisis pregnancy center were more likely to experience high levels of violence, threats, and harassment. Anti-choice extremists have bombed clinics, killed providers and staff, threatened and exposed the personal information of providers and staff, and shamed and humiliated patients. Those who provide this care live under constant threat.

21. For these reasons, the careful screening of potential staff members before hiring is an essential security precaution at Hartford Gyn. Like that of most private companies, the goal of an effective background check is to provide an accurate assessment of the applicant's

qualifications. As an abortion provider, however, we also assess additional material related to an applicant's reputation, reliability, truthfulness, and objectivity based on the very real concern that an anti-abortion extremist could harm the clinic. We also work to ensure that the patient will be provided care by someone who supports their right to make decisions about their own healthcare and will treat patients in a nonjudgmental and supportive manner. This robust process contributes to the substantial administrative and staff resources expended by facilities providing abortion care services. The Rule creates an opening for anti-abortion extremists to infiltrate and incapacitate our clinic by undermining this process and creating threats to security as well as to the basic right of the patient to non-judgmental supportive care in a safe environment that protects their quality of care, confidential medical information, and dignity.

22. Because our clinic's mission is to provide access to reproductive healthcare services, for all staff and virtually all others working at the clinic, such as contracted cleaning staff, working at Hartford Gyn necessarily involves some kind of connection to abortion care or contraception, and the clinic procedures and practices are designed to ensure our patients receive the highest quality, non-judgmental care. The clinic must operate efficiently due to its already limited income, but in order to do so, all staff must perform functions that touch on the provision of abortion and/or contraception. For example, receptionists' job duties include scheduling patients for abortion and contraception appointments. Similarly, our bookkeeper's job duties include preparing billing for all of the services we provide. There is no alternative human resources structure that could sustain the clinic. To the extent that the Rule would force us to change our structure, we would be forced to close.

23. Similarly, if individual staff could delay or deny care or give incomplete information about medical options based on their own beliefs, our clinic could not function properly, particularly in emergency situations. Such actions would disrupt our mission by failing to honor the beliefs and choices of our patients and by breaking down the trust central to our model of care and to the sustainability of our business.

24. In addition to the staffing and policy issues discussed above, the Rule will create tremendous uncertainty. Because the Rule is written so broadly, we are unable to determine what

our rights and our obligations are under the Rule on the day it goes into effect. Given the Rule's breadth and lack of clarity, we cannot accurately predict what we must do to comply, particularly in an emergency, while maintaining our mission and the quality of our patient care. The Rule puts the clinic in an untenable and unacceptable position.

25. If we cannot seek to ensure that our patients receive compassionate, non-judgmental care from every person they encounter in the clinic, we will no longer serve our central purpose.

26. That purpose is to provide essential reproductive healthcare services, including abortion and contraception, in a time when such care is stigmatized and threatened in the United States. The many barriers to care now inherent in healthcare systems—legal restrictions, funding limitations, stigma, among others—can be insurmountable. For many of our patients, Hartford Gyn is the provider of last resort.

27. We strive to empower patients to make their own, autonomous choices. We believe that respecting women's autonomy builds stronger communities and positive social change. This belief inspires our patient-centric approach to care. In order to empower patients to make decisions that support their health and are best-suited for them, we must provide comprehensive, medically-accurate information about our patients' medical options. To that end, we train and expect our staff to support patients with the resources, tools, and medical services they need to realize their choices.

28. When patients arrive at Hartford Gyn, they often comment on the kindness and compassion of the staff and the holistic care we provide. This response is often in some part the result of previous ill-treatment at crisis pregnancy centers or other healthcare facilities.

29. For example, last year, a 21-year-old patient scheduled an appointment with Hartford Gyn. On her way to her appointment, the patient and her mother were instructed to enter Hartford Women's Center, the crisis pregnancy center that opened next to our clinic. An employee of the crisis pregnancy center told the patient and her mother to "come in here" and then proceeded to tell her that if she had an abortion, she would be "sinning" and that she "might not make it out alive." After wasting significant time, being misinformed about numerous aspects

of abortion care, and treated with hostility and condemnation, they were ultimately told that "[t]here is no abortion center here." Unlike countless other patients faced with the same misinformation, the patient was able to find her way to her appointment. Once at Hartford Gyn, the patient reported feeling shame and fear. Our staff spent time with the patient to explain that she had spoken with someone who was not a medical professional and who had given her false information. This patient expected and was entitled to unbiased, non-coercive pregnancy counseling and abortion care from medical professionals.

30. Many patients face similar barriers to reproductive healthcare even at legitimate healthcare institutions, including Catholic hospitals. For an increasing number of communities, the closest or only hospital is a Catholic hospital operating under the guidance of the *Ethical and Religious Directives for Catholic Health Care Services* which govern certain practices at Catholic hospitals. Our patients frequently report that after presenting to their closest emergency room for evaluation, a positive pregnancy test was met with "congratulations!" and a refusal to provide requested resources or referrals to a center that would offer abortion care services. This refusal to provide comprehensive options and referrals causes delays in accessing time-sensitive abortion care, instills shame and fear in patients, and threatens severe health consequences.

31. Even at secular hospitals, there are often limits on the scope of care that is provided, either because of the refusal of an official in power or due to a lack of commitment to providing comprehensive reproductive healthcare, which is often accompanied by an assumption that care will remain available at independent providers like Harford Gyn.

32. Women seeking abortion and contraception, and the providers of such care, have been vilified in many places in the U.S. Anti-abortion activists have caused immeasurable harm, including killing abortion providers, threatening patients, infiltrating clinics, and spreading false information about patients, providers, and reproductive healthcare options, among other security concerns.

33. Hartford Gyn serves a special role in the provision of abortion care locally and nationally, and it is particularly vulnerable to closure if it loses its Medicaid funding. The community and the broader public consider Hartford Gyn to be a responsible and trustworthy

medical provider because we have provided nonjudgmental, objective, and compassionate care to women for four decades.

34. We will not continue to operate if we cannot follow our best practices to avoid further harm to and further stigmatization of patients seeking reproductive healthcare. To the extent that the Rule is inconsistent with the practices that protect our patients' health, ensure nondiscrimination, and make it financially and logistically feasible to operate, we will be forced to risk the loss of all funding and closure.

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

Executed on 9/29/19 in Hartford, Connecticut,

Elizabeth Barnes
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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA et al,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C 19-02405 WHA
Related to
No. C 19-02769 WHA
No. C 19-02916 WHA

DECLARATION OF ROBERT BOLAN, MD, CHIEF MEDICAL OFFICER, LA LGBT CENTER, IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date:	October 30, 2019
Time:	8:00 AM
Courtroom:	12
Judge:	Hon. William H. Alsup
Action Filed:	5/2/2019

I, Robert Bolan, declare as follows:

1. I am the Chief Medical Officer and Director of Clinical Research for the LA LGBT Center. I oversee all medical care related services at the LA LGBT Center, as well as maintain a panel of patients for whom I provide direct care. In addition, I oversee the LA LGBT Center's Research Department, am the principal investigator for multiple HIV treatment and prevention trials, and have written and presented extensively on various matters related to the care and treatment of people living with or at risk of acquiring HIV and other sexually transmitted infections (STIs). I am also Clinical Associate Professor of Family Medicine at the University of Southern California (USC) – Keck School of Medicine, and an Adjunct Clinical Professor of Pharmacy Practice at the Western University of Health Sciences. I received my medical degree from the University of Michigan Medical School, interned at St. Mary's Hospital Medical Center, and completed my residency at St. Michael Family Practice Residency. I was the Director of HIV Services in the Department of Family Medicine at the USC Keck School of Medicine, and I have been honored with the Leadership Award from the San Francisco AIDS Foundation. I maintain active board certification with the American Board of Family Physicians and specialty certification with the American Academy of HIV Medicine. I submit this declaration in support of Plaintiffs' Motion for Summary Judgment and in support of their opposition to Defendants' Motion to Dismiss or, in the alternative, for Summary Judgment.

2. As the Chief Medical Officer, I oversee the delivery of healthcare for approximately 9000 patients who come to the LA LGBT Center and have a panel of approximately 300 patients for whom I personally provide medical care. Over 90% of my patients identify within the LGBTQ communities. My patient population is also disproportionately low-income and experiences high rates of chronic conditions, homelessness, unstable housing, trauma history, and discrimination and stigmatization in healthcare services. Many of these patients come to me from different areas of California, other states, and even other nations to seek services in a safe and affirming environment.

3. Our healthcare services span the full spectrum of primary healthcare services, including, but not limited to, HIV treatment and testing, treatment and prevention of sexually

transmitted infections, as well as treatment for gender dysphoria, mental-health disorders, and substance-use disorders.

4. Many if not most of the individuals in our very diverse patient population face considerable stigma and discrimination – as people living with HIV, as sexual or gender minority people, as people of color. In addition, there is a very high incidence of other social determinants of poor health outcomes among our population. These include homelessness, food insecurity, lack of access to transportation, and lack of employment opportunities.

5. Furthermore, there is every reason to believe that the Denial-of-Care Rule will encourage healthcare providers and staff to claim the absolute right to refuse care or opt out of serving patients with particular needs, based on personal beliefs, which will result in more discrimination against LGBT patients and patients living with HIV at other clinics, doctors' offices, hospitals, pharmacies, and other healthcare facilities outside the LA LGBT Center. I, and the other providers that I supervise at the Los Angeles LGBT Center, have many patients who have experienced traumatic stigma and discrimination – based on their sexual orientation, gender identity, HIV status, and/or other factors – even before the Denial-of-Care Rule was proposed or issued. Based on the stories that my patients have shared with me, this discrimination, mistreatment, and denial of healthcare services has been motivated by the personal moral or religious beliefs of other healthcare providers and staff outside of the LA LGBT Center.

6. Over the twenty years I have been at the Center I have listened to the stories of countless individuals who have suffered overtly homophobic remarks from healthcare providers and who were either refused care or given clearly inadequate and inappropriate care because of their sexual orientation or gender identities. One of the most egregious examples was a transgender woman who needed extensive surgery to repair diffuse damage done by silicone injections into her breasts several years earlier. In 2009, she was turned away from an academic plastic surgery center in Los Angeles after the surgeon said her problem was caused by her own poor decision-making and she would therefore not be considered for treatment.

7. Incidents like this reveal that many healthcare providers and other staff harbor explicit or implicit biases against LGBT people. Because of legal requirements, healthcare

facility non-discrimination policies, and professional norms, many of them have kept their personal beliefs and feelings in check. By empowering healthcare staff to think that they have the legal right to act on their personal beliefs, even at the expense of patient needs, the Denial-of-Care Rule is very likely to result in many more incidents of discrimination and greater harm to LGBT individuals struggling with mental-health or substance-use issues, including the patients whom I treat and whose treatment I supervise.

8. Such experiences are not only insulting and demoralizing for the patient, but can jeopardize the patient's health, when a screening or treatment is denied or postponed, or the patient is discouraged from seeking medical care out of fear of repeated discrimination. Many if not most of my and the LA LGBT Center's transgender patients express strong distrust of the healthcare system generally and are reluctant to seek care outside the LA LGBT Center unless they are in a crisis or in physical or mental stress. This is because they want to avoid discrimination or belittlement. Such incentives to avoid regular check-ups and other medical care can result in disease processes that are more advanced at diagnosis, less responsive to treatment, or even no longer curable in the case of some cancers.

9. In the case of the transgender woman I described above, her general medical condition gradually deteriorated over the several years it took for me to finally identify a surgeon who would take her case. She was suffering from systemic metabolic complications from the chronic inflammation and skin breakdown caused by the hardened subcutaneous silicone injections. I feared for her survival. Fortunately, the surgeon who cared for her did so with kindness, respect, and compassion, and the patient has had an excellent result. The surgeon saved her life. Nevertheless, the ultimate tragedy in my patient's case was that after the humiliating and callous abuse to which she was subjected by the academic center's specialists, she was completely unwilling to even consider seeing another surgeon for the next six-and-a-half years. Her suffering during that time was completely avoidable had she been treated with basic human respect.

10. With existing health and healthcare disparities affecting the LGBTQ community – particularly the shortage of LGBTQ/HIV culturally competent providers – the Denial-of-Care

Rule's vague and confusing language will further exacerbate existing barriers to healthcare and result in negative community health outcomes. Good medical care is based on trust as well as frank and full communication between the patient and their provider. In many, if not most encounters, providers need patients to fully disclose all aspects of their health history, sexual history, substance-use history, lifestyle, and gender identity in order to provide appropriate care for the patients' health, both physical and mental. Incomplete communication, or miscommunication, can have dangerous consequences. For instance, a patient who conceals or fails to disclose a same-sex sexual history may not be screened for HIV or other relevant infections or cancers; and a patient who fails to fully disclose their gender identity and sex assigned at birth may not undergo medically-indicated tests or screenings (such as tests for cervical or breast cancer for some transgender men, or testicular or prostate cancer for some transgender women). Patients need to be encouraged to fully disclose all information relevant to their healthcare and potential treatment, which can only be achieved when patients are assured that the information they provide will be treated confidentially and with respect. The Denial-of-Care Rule endangers the provider-patient relationship, and is likely to harm many patients' health, by discouraging patients from full disclosure, and by encouraging providers to avoid topics that may offend their personal moral or religious beliefs in their encounters with patients.

11. The Denial-of-Care Rule will cause LGBT patients and patients living with HIV to lose trust in their healthcare providers (either out of fear of discrimination or on account of being denied care on religious grounds). The Rule will cause LGBT patients to attempt to hide their LGBT identities to an even greater degree when seeking healthcare services, especially from religiously-affiliated healthcare organizations, in order to avoid discrimination. The Denial-of-Care Rule endangers the provider-patient relationship, and is likely to harm many patients' health, by discouraging patients from full disclosure about their gender identity, sexual orientation, or related medical histories. Patients will avoid raising any topics, questions, facts that they fear could possibly offend their healthcare providers' personal beliefs, resulting in harm to patients.

12. The Denial-of-Care Rule is also likely to cause an increase in demand for my healthcare services because I have seen a spike in behavioral and mental-health issues resulting from religious or moral-based discrimination and denials of healthcare services.

13. The Denial-of-Care Rule is in direct conflict with the oath I swore as a doctor and many of the federal, state, and insurance rules, regulations, and statutes that I am required to follow. This has personally caused me great confusion and stress as it is unclear how I can work collaboratively with my colleagues who discriminate against or deny care to my patients without violating either current ethical and legal standards or the Denial-of-Care Rule.

14. As a healthcare provider with the LA LGBT Center, I receive various forms of federal funding directly and indirectly via federal programs, including but not limited to those governed by the Centers for Medicare and Medicaid Services through Medicaid and Medicare reimbursements and the Ryan White Comprehensive AIDS Resources Emergency Act of 1990. I may be, therefore, subject to the restrictions of HHS's Denial-of-Care Rule. These funds and related benefits account for a significant portion of my work and the healthcare services that I, and those that I supervise, provide to patients. Without such funding, we could not provide proper treatment to our patients, especially because a large portion of the population that we serve relies heavily on Medicaid and Medicare for its healthcare needs. I, therefore, have a reasonable fear that I could be sanctioned and lose federal funding for the work that I do as a result of nondiscrimination policies that I enforce in my department and amongst the staff that I supervise – polices that are vital to providing proper care to my patients and other patients whose care I supervise. If such a loss of funding were to occur, it would result in service reductions if not closure of our programs in their entirety.

15. The "Denial-of-Care Rule" is inherently demeaning and codifies our government's belief that providers' freedoms are the most important and that patients are supplicants when they seek healthcare. This proposed rule is shameful.

16. As LA LGBT Center's Chief Medical Officer and Director of Clinical Research, my responsibility includes enforcing our nondiscrimination mandate with respect to all of our providers and staff, including those working on federally funded research. I, therefore, have a

reasonable fear that the ability to provide federally funded healthcare services and conduct federally funded research could be severely impeded potentially putting patients and research participants at risk. I could also be subject to sanctions as the principal investigator for many federally funded research programs at the LA LGBT Center.

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

Executed on September 10, 2019, in Los Angeles, California.

Robert K. Bolan MD.

Robert Bolan, MD

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA et al,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C 19-02405 WHA
Related to
No. C 19-02769 WHA
No. C 19-02916 WHA

DECLARATION OF DR. BRAD BUCHMAN IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date:	October 30, 2019
Time:	8:00 AM
Dept:	12
Judge:	Hon. William H. Alsup
Trial Date:	None Set
Action Filed:	5/2/2019

I, Dr. Brad Buchman, declare:

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

2. I earned my medical degree at the University of California, San Diego. I also completed my residency in Family Medicine and a fellowship in Sports Medicine there. I am licensed to practice medicine in the State of California and I am Board-certified by the American Board of Family Medicine.

3. Since 2016, I have worked for UC Health as Chief Medical Officer for Student Health and Counseling and Chief Medical Officer for the Student Health Insurance Plan (UC SHIP). Before joining UC Health, I served as Chief of Family Medicine at UC San Diego Health's Department of Family Medicine and as Associate Medical Director of the UC San Diego Medical Group. I subsequently held positions as Medical Director at UC San Diego's Student Health Services and at UC Berkeley's University Health Services.

4. All ten University of California campuses also have a student health center, available to all UC students regardless of their health insurance carrier. Medical services at the Student Health and Counseling Services (SHCS) facilities include: Primary Care, Urgent Care, Pharmacy, Laboratory, Radiology, Physical Therapy, Immunizations, Social Services, Optometry, and various specialty services. Drop-in urgent care services are available at most campuses for sudden, serious, and unexpected illnesses, injuries or conditions which require immediate medical attention. Additionally, all campuses provide access to a nurse advice and mental health crisis lines twenty-four hours a day, seven days per week.

5. Many students elect to enroll in UC SHIP, a student health plan that provides additional coverage for campus-based services, as well as coverage for referral to local network-based specialty care and facilities if needed. UC SHIP also provides seamless referral and claims processing assistance coordinated by insurance personnel located at the campus health centers.

Also, telemedicine access to physician services is available to all students, and insurance coverage for these services is included for UC SHIP enrollees.

6. During academic year 2017-18, the UC Counseling and Psychological Services (CAPS) centers provided over 132,000 individual counseling visits to over 35,000 unique students, which is approximately 13% of total student enrollment at UC. CAPS also provided outreach to over 63,000 students via a variety of campus programs, and, separately, over 2,800 counseling group visits in 2017-18. CAPS additionally provided over 12,000 consultations during the past academic year to faculty, staff, or students to assess mental health concerns relayed about other students or campus community members. During the academic year 2017-18, UC SHCS centers provided over 30,000 psychiatry visits system-wide, representing a 17% increase in visit volume over the past two academic years. Of note, the centers provide a full range of women's health services, including, but not limited to, STI prevention and testing, contraception, referrals for medical or surgical abortion. UC also has an immunization policy in place for the past three years, which requires all incoming students to have received vaccination or demonstrate immunity to a number of aerosol transmissible diseases.

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

8. The Rule creates a broad exemption to opt out of any healthcare service based on a moral or religious ground (right granted to medical provider but also to anyone with an articulable connection to the provision of that service, including helping to make arrangements for that service). Specific potentially relevant scenarios are included in the Rule: abortion, certain vaccinations if there is an "aborted fetal tissue" connection (rubella, polio, Hepatitis A, chickenpox, small pox), contraception, and gender transition/gender dysphoria (counseling, administering hormone prescriptions, etc.), tubal ligations, hysterectomies, and assisted suicide. There does not appear to be any exception provided for emergency situations under the Rule.

9. For SHCS centers, the Rule's biggest impact would arise with respect to women's health providers to the extent that providers might object to a core set of services that make up the bulk of one's job description. Because demand for women's health services is consistently high, re-scheduling providers or other staff who object to a large portion of these services may create unequal workloads, patient awkwardness and inconvenience, and – for providers who are solely involved in the provision of women's services – potentially difficult HR scenarios where women's health providers may not be able to fulfill significant portions of their job responsibilities.

10. The SHCS centers include services such as immunization/vaccinations, family planning, STD/STI screening, transgender care, and referrals for these and follow-up services where appropriate. The Rule appears to target many of these services for potential refusal which could hinder the provision of these services to students. The Rule could also hinder the provision of services to LGBTQ students, including counseling services that members of this community could seek out.

11. The elimination of federal funding to UC would be devastating for the system. If federal support for student financial aid were removed, this could have a large impact on the UC SHIP insurance program, decreasing student enrollment, thus reducing the funding of the plan and increasing the potential for rate instability, as well as decreasing an important revenue source for the Student Health and Counseling centers via a loss of UC SHIP billing for services.

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

Executed on this 11th day of September, 2019 in Oakland, California.

Brad Buchman, MD
Chief Medical Officer
UC Student Health and Counseling
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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
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STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
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COUNTY OF SANTA CLARA et al,
Plaintiffs,
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C 19-02405 WHA
Related to
No. C 19-02769 WHA
No. C 19-02916 WHA

DECLARATION OF JULIE BURKHART IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date:	October 30, 2019
Time:	8:00 AM
Dept:	12
Judge:	Hon. William H. Alsup
Trial Date:	None Set
Action Filed:	5/2/2019

I, Julie Burkhart, declare:

1. I am the Founder and Chief Executive Officer of Trust Women, which operates clinics that provide full-spectrum reproductive healthcare and certain health services to the LGBTQ community.[1] Trust Women operates clinics in Kansas, Oklahoma, and Washington State with the goal of ensuring affordable access to abortion, contraception, LGBTQ healthcare, and other reproductive healthcare services.

2. I submit this Declaration in support of Plaintiffs' challenge to the final rule promulgated by the Department of Health and Human Services ("HHS") relating to "Conscience Rights in Health Care" (the "Rule") and the Rule's enforcement by the HHS Office of Civil Rights ("OCR").

3. Trust Women Seattle, located in Seattle, Washington, opened in June 2017 and provides reproductive healthcare, including abortion services, contraceptive care, and general gynecological care, as well as a growing number of services for LGBTQ patients, including the provision of gender-confirmation hormone therapies. The clinic receives Medicaid funding.

4. Trust Women's mission is to operate clinics that empower our patients to make autonomous decisions about their healthcare in a compassionate and non-judgmental environment. It is essential to Trust Women's mission that patients be treated with dignity, empathy, and respect, given complete and accurate medical information, and be empowered to make decisions about their health and lives free from judgment or disruptions in their care. Given our structure and the interactions that most staff have with patients and the provision of care, we seek to ensure that all staff treat each patient with dignity and compassion and respect patient autonomy.

5. Trust Women Seattle endeavors to protect our patients from judgment also because we offer services that are stigmatized and under threat in the U.S. We have seen the harm prejudice and judgment impose on our patients, including in their ability to access needed healthcare. For example, many of our patients come to us after being turned away from another

[1] This term refers to lesbian, gay, bisexual, transgender, and queer/questioning people and other sexual and gender minority individuals.

provider.

6. To that end, Trust Women Seattle has a "no turn away" policy. For each patient, the clinic staff work to utilize healthcare benefits fully and raise any additional money from donors and other funds, if necessary. This practice ensures that we see patients regardless of their ability to pay.

7. This policy is largely contingent on the continued availability of state Medicaid reimbursement. If the clinic did not receive this income, it would have to attempt to raise significantly more money from contributors and other sources, which is not presently available, and extremely unlikely to be secured solely through these sources.

8. In 2018, approximately 64% of our abortion patients relied on Medicaid; approximately half of our patients receiving contraception relied on Medicaid; and approximately 60% of our income from providing transgender healthcare came from Medicaid.

9. Only 2 patients in the history of the clinic have been denied Medicaid coverage—one due to residency ineligibility and the other due to income above the threshold. The clinic relies on Medicaid approvals to provide services.

10. I understand that Trust Women Seattle is considered a "subrecipient" under the Rule because it receives Medicaid funding through Washington State, which receives that funding as a direct recipient of HHS Medicaid funding.

11. I understand that the Rule states that "any entity that carries out any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of [HHS]," is prohibited from "requir[ing]" any "individual to perform or assist in the performance of any part of a health service program or research activity if such performance or assistance would be contrary to the individual's religious beliefs or moral convictions."

12. I understand that an "entity that carries out any part of a health service program or research activity" funded through HHS includes subrecipients, like Trust Women Seattle, who receive Medicaid reimbursement through state programs under the Rule.

13. Were it to take effect, the Rule would impose immediate compliance and

administrative costs. First, in order to ensure compliance, the clinic would need to hire an attorney to review the Rule and our policies. The clinic must also maintain records of its compliance, although the Rule does not specify the form of these records. The Rule states that patient privacy is not grounds to refuse access to OCR when it seeks to inspect records. To the extent that the Rule allows OCR access to unredacted patient information and internal clinic records, it is extremely problematic. Our mission is to protect and empower our patients—opening patient records to inspectors who may be hostile to our mission is antithetical to our central purpose.

14. The clinic will also be subject to investigation or inspection by HHS, which I understand can be initiated by HHS based on a complaint or even in the absence of a complaint. I understand that under the Rule, OCR must conduct an investigation "whenever a compliance review, report, complaint, or any other information found by OCR indicates a threatened, potential, or actual failure to comply with Federal healthcare conscience and associated anti-discrimination laws or [the Rule]." The Rule is silent as to whether HHS must inform the clinic of an investigation or follow any particular procedure with respect to these investigations or inspections. The Clinic must cooperate with these measures, although the Rule is also silent as to the specific requirements of such cooperation.

15. Unannounced inspections and investigations can be very problematic for a small provider. At Trust Women's Kansas clinic, for example, we are already subject to significant scrutiny. The Board of Healing Arts in Kansas subpoenas information from our clinic and inspects the clinic without notice. These actions are based on "complaints" that have invariably been baseless and inappropriate allegations. The Department of Sanitation has also preformed unannounced inspections. All of these inspections and the production of information and records require costly advice from local counsel and the commitment of extensive staff resources, which together divert funds and personnel from our primary mission. We are targeted for these burdensome actions simply because we provide abortion.

16. Across the country, independent family-planning and other specialized reproductive-healthcare clinics are singled out for excessively burdensome treatment at the local,

state, and federal level. As another example, in Oklahoma, Trust Women applied for two types of licenses. The Department of Health sat on the applications for 12 months, and we ultimately needed legal counsel to help get the process moving. To the extent that the Rule will impose such burdens on all independent clinics at the federal level, it is unworkable.

17. I understand that if OCR finds a violation of the Rule, OCR may withdraw or even clawback our funding. I understand that under the Rule, Washington State's Medicaid program, as the direct recipient that provides our Medicaid dollars, also bears "primary responsibility" for Trust Women Seattle's compliance with the Rule and stands to lose its HHS funding should Trust Women fail to comply with the Rule, incentivizing the program to discontinue its commitment to funding reproductive healthcare and services to LGBTQ patients. I further understand that under the Rule, the conduct or activity of contractors is "attributable" to the state for the purposes of enforcement or liability under the Weldon Amendment, further disincentivizing continued funding to the clinic. These enforcement mechanisms could shutter our clinics.

18. The Rule is unworkable for Trust Women Seattle. To the extent that it would prevent us from continuing to operate our business, force us to change core policies, or incite staff to exercise a unilateral veto over patient access to information and care, it would be extremely harmful for both our patients and our reputation, would cause devastating harm to our business, and would undermine our mission.

19. Small medical practices like Trust Women Seattle are specialized. We hire staff with special skills to work in our clinic, including staff sensitive to the experiences of women seeking abortion, contraceptive, and services for LGBTQ patients and medical staff with experience in assisting with gynecological care. Many staff members who work at the clinic have a connection to abortion care, contraception, or LGBTQ services, even if it only involves scheduling or doing bookkeeping or other administrative tasks related to such services. Trust Women Seattle is a small business, and part of our business model is to cross-train clinical and some non-clinical staff to serve multiple roles, many of which touch on providing information about, scheduling, or directly providing abortion, contraception, or transgender care. For example, some employees focus on recording compliance with medical standards, which includes

monitoring the provision of abortion care and contraceptive care at the clinic. Others perform medication management, sanitize instruments, and clean operating rooms and laboratories that may be used for general gynecological exams one day, and the provision of contraception or hormone therapy the next.

20. Although these activities do not involve the direct provision of care, if an employee were to refuse to participate in precisely these types of services, it would force a change in staffing structure that would be extremely costly and unworkable for the clinic. Likewise, if any employee were to unilaterally turn away a patient away seeking information or services, it would compromise our ability to provide healthcare services to our patients—the crux of both our mission and business. To the extent that we would have to ensure that all employees were not opposed to a new service anytime we add any services to our practice, it would significantly compromise our ability to expand our services and our resources.

21. Trust Women Seattle also has an emergency policy requiring all office personnel to be familiar with transfer agreements in the case of an emergency. This policy requires that any staff member assist in an emergency transfer, even if only by calling ahead to the hospital. To the extent that the Rule would prevent us from continuing to enforce this policy, it would be unworkable.

22. Were the Rule to prevent the clinic from requiring that staff members interact with all patients without judgment, it would likewise be unworkable. To the extent that we would be prevented from requiring that front-facing employees like receptionists, who do not assist in procedures according to our present understanding, be compassionate and supportive of the independent decision-making of our patients, it would undermine both our business and inhibit our patients' access to healthcare.

23. Patients at Trust Women Seattle have conveyed that they have been disrespected and demeaned by other healthcare providers for making independent decisions about their healthcare, including past and present reproductive healthcare choices. Likewise, transgender patients have thanked us for addressing them with their chosen identity because they have been to healthcare providers who have refused to use their chosen pronouns or name based on prejudice.

Our core mission is to treat all patients with dignity and compassion and, above all, to respect the autonomous choices of our patients. This mission is our central focus because we understand that many of our patients, and many patients around the country, have been marginalized in seeking needed medical services.

24. If, contrary to our practice of empowering patients to make their own decisions, employees were to substitute their opinions about a patient's care for the patient's judgment—essentially exercising a unilateral veto over the patient's receipt of care or information—and the clinic was rendered powerless to protect our patients without risking total loss of funding, we would either be forced to abandon our core mission or close.

25. We are concerned that, for example, an employee who supports access to contraception might be opposed to abortion or to abortion after a certain stage in pregnancy. Alternatively, staff who support abortion access may be willing to serve patients seeking reproductive healthcare but be opposed to treating members of the transgender community. Personal opinions can fall on a spectrum, and we are particularly vulnerable because of the breadth of services we provide and the varied communities we serve. We would be in a particularly untenable position if someone comes to assert a refusal after they were hired and staffed.

26. Extreme anti-abortion or anti-LGBTQ activists also pose a significant threat to the clinic and our staff, a threat that may become more significant if the clinic is unable to exercise the necessary controls within the clinic to protect patients and patient care. Because of the intense opposition to abortion and the ongoing presence of protestors outside our clinic, we are keenly aware of security threats posed by those who radically oppose abortion. It would be extremely dangerous to our staff and patients to have anyone on staff who would pose such a threat, and, to the extent that the Rule renders us powerless to prevent it, we would be forced to either assume that risk or risk total loss of and even clawback of federal funding. Further, patients and their communities trust us to be a safe place for them to receive nonjudgmental care and information. We would lose that trust and potentially sacrifice the safety of everyone in the clinic were we to compromise our mission in response to the Rule.7

27. To the extent the Rule would require Trust Women to change our cross-training and staffing policies or abandon our emergency policies, it would be impossible for Trust Women to continue providing abortion, contraception, and LGBTQ care.

28. It is unlikely, if not impossible, for the clinic to qualify for enough alternative funding from non-Medicaid sources to survive. At present levels, we could not survive.

29. Whether we continue to operate while constraining our provision of abortion, contraception, or LGBTQ services, or instead close altogether, our patients will suffer. Many of our patients rely on us for abortion, contraception, and transgender care that they cannot access anywhere else.

30. Even if we could continue operating by, for example, incorporating another type of practice to supplement the clinic's income, we would have to lay off staff and sacrifice our core mission to provide reproductive healthcare and services to LGBTQ patients. Further, that could not be achieved without fundamentally altering our business model and finding a new location, hiring additional specialized staff and physicians, purchasing new equipment, and retaining specialized administrative support. In short, incorporating another practice to stay open would completely undermine the mission and purpose of our clinic.

31. If we do close, it will be very difficult to reopen. Opening any kind of medical practice is complicated. It requires licensing, finding appropriate space, new equipment, supplies, insurance, and credentialing. Reopening our Seattle clinic after a closure would likely cost in excess of $2,000,000 and, in Seattle, only 7% of downtown real estate is available for rent at all.

32. The Rule thus creates an impossible choice—either fundamentally change the way we operate, potentially compromising our core mission to provide compassionate reproductive healthcare and care to the LGBTQ community, or risk the loss of all funding and closure.

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

Executed on 3 Sept. 2019 in Wichita, Kansas,

Julie Burkhart
Founder and CEO, Trust Women

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA et al,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C 19-02405 WHA
No. C 19-02769 WHA
No. C 19-02916 WHA

DECLARATION OF MARI CANTWELL IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date: October 30, 2019
Time: 8:00 AM
Courtroom: 12
Judge: Hon. William H. Alsup
Action Filed: 5/2/2019

I, Mari Cantwell, declare:

1. I am the Medicaid Director for the State of California and Chief Deputy Director of Health Care Programs at the California Department of Health Care Services (DHCS). I have held the Chief Deputy position since 2013 and the State Medicaid Director position since 2015. I have worked in the field of health care policy and finance for almost 20 years. Prior to the positions I hold now, I served as the Deputy Director of Health Care Financing for DHCS, and previously as the Vice President of Finance Policy for the California Association of Public Hospitals and Health Systems. I hold a B.A. in Public Policy from Brown University, and a Masters in Public Policy with a focus in Health Policy from the University of California, Los Angeles.

2. DHCS has the mission to provide Californians with access to affordable, integrated, high-quality health care, including medical, dental, mental health, substance use treatment services, and long-term care. Our vision is to preserve and improve the overall health and well-being of all Californians. DHCS administers and oversees multiple federally-funded health care programs, including Medicaid, Children's Health Insurance Program, and several health-related federal grants. DHCS funds health care services for approximately 13 million members of Medi-Cal, California's Medicaid program. Among the programs administered by DHCS, some of which are mandated and/or financed by the federal government and others required by state law, are: Community Mental Health Block Grant; Substance Use Abuse Prevention and Treatment Block Grant; Medi-Cal Access Program; California Children's Services program; Child Health and Disability Prevention program; the Genetically Handicapped Persons Program; the Newborn Hearing Screening Program; the Family Planning, Access, Care, and Treatment program (Family PACT); Program of All-Inclusive Care for the Elderly, and Every Woman Counts. DHCS also administers programs for underserved Californians, including farm workers and American Indian communities.

3. I am familiar with the final rule entitled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority" (the Rule), published in the Federal Register on May 21, 2019, effective date November 22, 2019.

4. As discussed further below, I anticipate that the Rule will increase costs for DHCS and sub-recipients, and will likely have negative impacts to health care access in the State.

5. The Rule places at risk all federal funds DHCS receives from the U.S. Department of Health and Human Services, as well as from the U.S. Department of Education and the U.S. Department of Labor, if California is determined to be in violation of the Rule. DHCS is extremely dependent on the receipt of federal funding. The approximated total amount of federal funds DHCS received in the 2018-19 State Fiscal Year was $63.68 billion.

6. The Rule will impose immediate costs on DHCS, which will be incurred across the fee-for-service and managed care Medi-Cal delivery systems and various other health care programs administered by DHCS across the State of California. This includes, but is not limited to, the following activities: changes to internal and external DHCS webpages; preparation and physical posting of revised notices at all DHCS locations, including both for the public and for DHCS workforce; preparation and publication of revisions to DHCS applications, policy guidance and similar materials for providers, health plans, beneficiaries, other contractors or sub-recipients, and DHCS workforce; and providing notice to and overseeing implementation by all political subdivisions of the State, various DHCS contractors such as managed care plans, and various other sub-recipients of the implicated federal funds. As a preliminary estimate, DHCS projects immediate costs in the range of $3.5 Million to $4.5 Million (total funds). Such costs include projected staff and contractor expenses, as well as information technology/system costs over a variety of Medi-Cal delivery systems and other DHCS health care programs.

7. The Rule imposes significant ongoing recordkeeping and compliance costs on DHCS, particularly considering the many sub-recipients across various Medi-Cal delivery systems and separate DHCS-administered health care programs (potentially in the thousands or more). It is my understanding that a sub-recipient's violation of the Rule similarly places all federal funds at risk, in addition to DHCS compliance as a recipient. Medi-Cal sub-recipients include independent political subdivisions of the State, such as counties. In order to comply with the Rule's assurance/certification and compliance processes, 84 Fed. Reg. 23269–71 (codified at 45 C.F.R. 88.4, 88.6), DHCS will need to develop and maintain a comprehensive system for

tracking and monitoring compliance at DHCS, as well as compliance status of all sub-recipients to DHCS in the State. This system will require dedicated staff and contractor resources to fulfill the many compliance activities required in the Rule including, but not limited to: maintaining complete and accurate records of compliance with the Rule, including sub-recipients (45 C.F.R. 88.6(b)); tracking all accommodation requests and complaints across multiple programs (45 C.F.R. 88.6(b)(2)); facilitating investigation of DHCS or any sub-recipient (45 C.F.R. 88.6(c)); implementing, or overseeing sub-recipient implementation of, any corrective action required under the Rule (45 C.F.R. 88.6(a)); reporting of any recipient or subrecipient compliance reviews or complaints to the Office for Civil Rights for the past three years (45 C.F.R. 88.6(d)); and providing ongoing oversight of and training to the many sub-recipients across the State. As a preliminary estimate, DHCS projects annual recordkeeping and compliance costs in the range of $1 million to $2 million (total funds). Such costs include projected staff and contractor expenses, as well as information technology/system costs over a variety of Medi-Cal delivery systems and other DHCS health care programs.

8. In developing its annual budget, DHCS does so with the expectation that it will receive a projected amount of federal funds it is entitled to under federal law and its agreements with federal agencies, but are put at risk under the Rule. Given the joint federal-state nature of the Medicaid program, the federal funds on which DHCS relies each fiscal year are extensive, and implicated in nearly every activity contemplated under the DHCS budget, including both medical assistance and administrative expenditures. With the size and complexity of DHCS programs, the annual process for developing the Medi-Cal budget necessarily begins well in advance of the subject State's fiscal year. One of the most crucial components of that process is accurately projecting the approximate federal funding available for the myriad of DHCS activities addressed through the budget. These projections of anticipated revenues, most notably the available federal funding, are the foundation from which all spending decisions are made and policy priorities are set. Approximately one-third of California's population receives healthcare services through coverage financed or administered by DHCS, making the department the largest healthcare purchaser in California. A sudden, more-than-temporary disruption in anticipated federal funds

would cause budgetary and operational chaos, upending the foundational assumptions on which the budget is crafted and negotiated. This could have far-reaching detrimental consequences, not only for beneficiaries accessing covered services, or providers and managed care plans receiving payment for rendering services, but also could complicate or in some cases halt ongoing administration of the programs at the State and local levels.

9. Any gap in federal funding or protracted period of significant federal funds being withheld from California, or worse yet a permanent loss of federal funds, would force the State to consider significant, devastating, and consequential spending reductions to make up for lost funding that could not be replaced with new State revenue sources. Due to mandates in federal Medicaid law, these options would be limited to program areas where California exceeds federal minimums, for example optional benefits or eligibility groups, or supplemental or enhanced payments for providers or managed care plans. Such cuts would likely constrain access to healthcare for affected populations and underserved communities statewide, leading individuals to either forego necessary care or resort to more costly emergency settings, and the impact of such increased uncompensated care costs would reverberate throughout the entire California economy, including putting a massive strain on the state's coffers.

10. The elimination of funding to DHCS would harm California's healthcare system and economy. Given the breadth and scope of this unprecedented rule, and lack of clarity and certainty around its enforcement, services to beneficiaries could be harmed.

11. The Rule will likely make it more difficult for beneficiaries of DHCS-administered programs to access an array of covered and medically necessary services. Given the Rule's expansive breadth, the potential for impeded access is not just with respect to a healthcare entity's ability to refuse to provide an affected service. Rather, that ability to abstain seemingly extends broadly and includes referrals and information sharing with a patient. Because of this, I believe it is likely the Rule will constrain provider supply and impede access to certain service categories, particularly in rural or otherwise underserved regions of the State. In addition, the potential for negative impacts would likely be disproportionately borne by vulnerable population groups, such as low-income women and the LGBTQ community. Further, these potential, negative impacts to

access would be significantly exacerbated in the event a sizable portion of federal funds is withheld due to a violation by DHCS or one of its many sub-recipients.

12. The Rule will also put women at greater risk of unintended pregnancies. My responsibilities at DHCS includes oversight of the Office of Family Planning (OFP) which is responsible for developing family planning policy in Medi-Cal and administering family planning-related programs. OFP administers the Family PACT program which is California's innovative approach to provide comprehensive family planning services to eligible low income men and women that do not otherwise qualify for full scope Medi-Cal coverage. The goal of FPACT is to ensure that low-income women and men have access to health information, counseling, and family planning services to reduce the likelihood of unintended pregnancy and to maintain optimal reproductive health. The intent of the program is to provide eligible California women and men access to comprehensive family planning services in order to establish the timing, number and spacing of their children and maintain optimal reproductive health. A rule that allows pharmacists and other providers to interfere with a woman's access to contraceptives and other reproductive health care will result in a hardship on the participants in this program likely leading to increased costs because of delays or other barriers to receiving desired services,

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

Executed on August 29, 2019 in Sacramento, CA.

Mari Cantwell
Chief Deputy Director, Health Care Programs
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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA et al,
Plaintiffs,
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C 19-02405 WHA
Related to
No. C 19-02769 WHA
No. C 19-02916 WHA

DECLARATION OF WARD CARPENTER, MD, CO-DIRECTOR OF HEALTH SERVICES,LA LGBT CENTER, IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date:	October 30, 2019
Time:	8:00 AM
Courtroom:	12
Judge:	Hon. William H. Alsup
Action Filed:	5/2/2019

I, Ward Carpenter, declare as follows:

1. I am the Co-Director of Health Services for the Los Angeles LGBT Center (LA LGBT Center), where I was formerly the Associate Chief Medical Officer as well as the Director of Primary and Transgender Care. I received my medical degree from the Robert Wood Johnson Medical School and had my residency at St. Vincent's Hospital Manhattan. I am board-certified in Internal Medicine and I hold certification in HIV Medicine. I am licensed to practice in the state of California. At the LA LGBT Center, I oversee all operations of the Federally Qualified Health Center ("FQHC"), including personnel, finances, clinical programs (mental health, psychiatry, primary care, HIV care, transgender health, substance abuse, and sexual health), nursing, case management, quality, risk management, and clinical research. I also maintain a panel of patients for whom I provide direct care. I submit this declaration in support of Plaintiffs' Motion for Summary Judgment and in support of their opposition to Defendants' Motion to Dismiss or, in the alternative, for Summary Judgment.

2. As the Co-Director of Health Services, I oversee the healthcare of over 17,000 patients who come to the LA LGBT Center for their care; I personally provide care to a panel of 150 patients. All of my patients identify within the LGBTQ communities, and approximately 30% of my patients are people living with HIV. My patient population is also disproportionately low-income and experiences high rates of chronic medical conditions, homelessness, unstable housing, extensive trauma history, and discrimination and stigmatization in healthcare services. Many of these patients come to me from different areas of California, other states, and even other nations to seek services in a safe and affirming environment.

3. I provide a wide spectrum of healthcare services, including, but not limited to, HIV treatment, testing and prevention; STD testing, treatment and prevention; general primary care with an LGBT focus; and comprehensive transgender care. I have worked in this field of medicine continuously since 2004 and have personally cared for over 4000 people in that time. I have worked in two Federally Qualified Health Centers, in New York and Los Angeles, as well as a private practice in New York. I am a nationally-recognized expert in the field of transgender medicine.

4. Many if not most of the individuals in our very diverse patient population face considerable stigma and discrimination – as people living with HIV, as sexual or gender minority people, as people of color. Transgender people have a 41% lifetime risk of attempting suicide. This shocking observation can be explained by the intense dysphoria inherent in living in a body and a society that does not reflect and validate who you know yourself to be at a core level. In order to avoid this tragic consequence, transgender people require compassionate, sensitive, and competent care that often includes medical and/or surgical procedures that incidentally affect reproduction. These patients have significantly improved mental health outcomes when able to proceed with the treatments they need. Treatments for gender dysphoria have been deemed medically necessary by the World Professional Association of Transgender Health and the Endocrine Society, in the same way that the American College of Cardiology has deemed treatment for hypertension medically necessary. In fact, in the course of treating gender dysphoria, endocrinologists and other healthcare providers use the same medications to treat transgender people as they use to treat non-transgender people with hormone deficiencies. Under the Denial-of-Care rule, medical personnel who are duty-bound to treat someone for one condition – hypertension – could legally refuse to treat that same person for another condition – gender dysphoria – that could become life-threatening if left untreated despite having the necessary tools and expertise to do so. Healthcare discrimination like this will have immediate negative consequences for a distinct and oppressed minority group and cannot be empowered, as it is in the Denial-of-Care Rule.

5. There is every reason to believe that the Denial-of-Care Rule encourages healthcare providers and staff to claim an absolute right to refuse care or opt out of serving patients with particular needs, based on personal beliefs, and will result in more discrimination, mistreatment, and denials of healthcare services against LGBT patients and patients living with HIV at other clinics, doctors' offices, hospitals, pharmacies, and other healthcare facilities outside the LA LGBT Center. Even before the Denial-of-Care Rule was proposed or issued, I and the other providers that I supervise at the LA LGBT Center have had many patients who have experienced traumatic stigma and discrimination – based on their sexual orientation, gender identity, HIV status, and/or other factors. For example:

a. A transgender patient went to a urologist due to uncomfortable urination lasting for several years after her vaginal surgery. She was repeatedly referred to as "sir" and "he" despite repeated requests to use the correct pronouns. When the patient confronted the clerk, the clerk said "this is what your ID says, so this is how we will refer to you." When she saw the doctor, he also called her "sir," completely humiliating her in the most unprofessional manner. He did not close the door to the exam room during their visit, so that the entire waiting room could hear his conversations with her, and he asked her to remove her pants in full view of the waiting room. She was so traumatized by this experience that four years later, she continues to live with daily pain rather than risk being subjected to discrimination by another transphobic urologist.

b. A transgender patient started bleeding profusely from her vagina one week after surgery. Because there are so few trans-competent surgeons in the United States, this patient's surgeon was thousands of miles away. When she finally spoke to an ER doctor, the physician looked disgusted and said "what do you want me to do about it?" then walked away. She had to pack her own vagina with gauze pads and leave the ER, not knowing if she would live or die, and only coming to see us three days later after having lost a significant amount of blood. These horrific incidents will increase as a result of the Denial-of-Care Rule. The likely result: patients will die.

c. A gay male patient with a serious and concerning neurological condition went to a neurologist. At this visit, the doctor had religious brochures throughout the waiting room. On arrival in the exam room, he was given a brochure about a particular Christian faith and asked if he had any questions. The patient felt extremely uncomfortable with this insertion of religion into what he felt should be a neutral space. As a result, he did not return for care

and experienced a delay of several more months trying to find a new doctor he could trust.

d. A person living with HIV was referred to a surgeon for a routine procedure. The surgeon sent a note back to the patient's primary care physician asking him to refer the patient to someone "who was more familiar with treating patients like him." Again, this patient waited another two months to have this surgery, which could have caused severe or life-threatening complications.

e. A lesbian woman went to her doctor and was told that lesbians are not at risk for HPV and, therefore, she did not need cervical cancer screening. This patient knew enough to find a new doctor, but many patients would accept this information as fact and never receive a Pap smear, significantly increasing their chances of dying from cervical cancer. This type of medical error based on discriminatory stereotypes demonstrates what will happen when medical personnel are invited to discriminate instead of focusing on the health needs of patients in their care.

f. A gay man went to his primary care physician with urinary burning and discharge. Because his healthcare provider did not ask, the provider did not know that this patient was sexually active with men. Therefore, the provider did only one test, which was negative, and sent him to a urologist. The urologist did another test, which was negative, then performed a procedure to look inside this man's bladder with a camera. It was not until he came to the LGBT Center that we performed a proper medical history and exam and were able to treat him immediately for his sexually transmitted infection. We also determined that he had sex with five other people from the time of his first symptoms to the time he was finally treated, weeks later. Had any of these providers stopped to ask the man about his sexual practices, they would have immediately tested him and treated him for a sexually

transmitted disease. Instead, he saw three providers, received hundreds of dollars in unnecessary testing and passed his infection along to five other people who themselves had to go down similar testing and treatment paths.

6. In sum, the message of these examples is clear: when patients are discriminated against, stereotyped, and mistreated in medical establishments as a result of healthcare providers' personal moral or religious beliefs, patients stop seeking care or their care is detrimentally delayed out of fear of repeated discrimination and denials of care. As a result, their conditions remain untreated for a much longer period of time, if they ever get treatment, resulting in much more acute conditions, ultimately costing the healthcare system millions of dollars in unnecessary expense while harming patients and public health. When medical staff fail to care for every patient in the best way that they can, putting patients' best interests at the center of medical care, medical mistrust is worsened, care is delayed, and healthcare becomes more expensive.

7. These incidents reveal that many healthcare providers and other staff harbor explicit or implicit biases against LGBT people and people living with HIV. Because of legal requirements, healthcare facility non-discrimination policies, and professional norms, many of them have kept their personal beliefs and feelings in check. By empowering healthcare staff to think that they have the right to act on their personal beliefs, even at the expense of patient needs, the Denial-of-Care Rule is very likely to result in many more incidents of discrimination and greater harm to LGBT individuals and patients living with HIV who are struggling with mental health or substance use issues, including the patients whom I treat and whose treatment I supervise.

8. Such experiences are not only insulting and demoralizing for the patient, but can jeopardize the patient's health, when a screening or treatment is denied or postponed, or the patient is discouraged from seeking medical care out of fear of repeated discrimination. Many if not most of my and the LA LGBT Center's transgender patients express strong distrust of the healthcare system generally, and a demonstrative reluctance to seek care outside the LA LGBT Center unless they are in a crisis or in physical or mental stress. This is because they want to avoid discrimination or belittlement. Such incentives to avoid regular check-ups and other medical care can result in disease processes that are more advanced at diagnosis, less responsive to treatment, or even no

longer curable in the case of some cancers. Already, my patients are arriving at the LA LGBT Center with more acute medical conditions than they would otherwise have because the increase in religious-based discrimination has caused patients to fear receiving necessary medical care.

9. With existing health and healthcare disparities that harm the LGBTQ community – particularly the shortage of LGBTQ/HIV culturally competent providers – the Denial-of-Care Rule's vague and confusing language will further exacerbate existing barriers to healthcare and result in negative community health outcomes. Good medical care is based on trust as well as frank and full communication between the patient and their provider. In many, if not most encounters, providers need patients to fully disclose all aspects of their health history, sexual history, substance-use history, lifestyle, and gender identity in order to provide appropriate care for the patients' health, both physical and mental. Incomplete communication, or miscommunication, can have dangerous consequences. For instance, a patient who conceals or fails to disclose a same-sex sexual history may not be screened for HIV or other relevant infections or cancers; and a patient who fails to fully disclose their gender identity and sex assigned at birth may not undergo medically-indicated tests or screenings (such as tests for cervical or breast cancer for some transgender men, or testicular or prostate cancer for some transgender women). Patients need to be encouraged to fully disclose all information relevant to their healthcare and potential treatment, which can only be achieved when patients are assured that the information they provide will be treated confidentially and with respect. The Denial-of-Care Rule endangers the provider-patient relationship, and is likely to harm many patients' health, by discouraging patients from full disclosure, and by encouraging providers to avoid topics that may offend their personal moral or religious beliefs in their encounters with patients.

10. The Denial-of-Care Rule causes LGBT patients and patients living with HIV to lose trust in their healthcare providers (either out of fear of discrimination or on account of being denied care on religious grounds). As a result, there will be an increase in demand for my and my department's services that will limit my ability to provide adequate care and time to my patients. This will increase wait times for my patients, and the delays in care may worsen conditions for which my patients are seeking treatment and outcomes of care.

11. The Rule will cause LGBT patients to attempt to hide their LGBT identities when seeking healthcare services, especially from religiously-affiliated healthcare organizations, in order to avoid discrimination. The Denial-of-Care Rule endangers the provider-patient relationship, and is likely to harm many patients' health, by discouraging patients from full disclosure about their gender identity, sexual orientation, or medical histories. Patients will avoid raising any topics, questions, facts that they fear could possibly offend their healthcare providers' personal beliefs, resulting in harm to patients. When patients are unwilling to disclose their sexual orientation and/or gender identity to healthcare providers out of fear of discrimination and being refused treatment, their mental and physical health is critically compromised.

12. The Denial-of-Care Rule is also likely to cause an increase in demand for my healthcare services because I have seen a spike in behavioral and mental-health issues resulting from religious or moral-based discrimination and denials of healthcare services.

13. The Denial-of-Care Rule is in direct conflict with the oath I swore as a doctor and many of the federal, state, and insurance rules, regulations, and statutes that I am required to follow. This has personally caused me great confusion and stress as it is unclear how I can work collaboratively with colleagues who may discriminate against my patients without violating either current medical ethical and legal standards of care or the Denial-of-Care Rule.

14. As a healthcare provider with the LA LGBT Center, I receive various forms of federal funding directly and indirectly via federal programs, including but not limited to those governed by the Centers for Medicare and Medicaid Services through Medicaid and Medicare reimbursements as well as funding under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 and funding from the Centers for Disease Control and Prevention. These funds and related benefits account for a significant portion of my work and the healthcare services that I, and those that I supervise, provide to patients. Without such funding, we could not provide proper treatment to our patients, especially because a large portion of the population that we serve relies heavily on Medicaid and Medicare for its healthcare needs. I may be, therefore, subject to the restrictions of HHS's Denial-of-Care Rule and have a reasonable fear that I could be sanctioned and lose federal funding for the work that I do as a result of nondiscrimination policies that I enforce

in my department and amongst the staff that I supervise, which is vital to providing proper care to my patients and other patients whose care I supervise. If such a loss of funding were to occur, it would result in service reductions if not closure of our programs in their entirety.

15. One of the guiding ethics of medicine is to treat all patients equally. We do not treat blue-eyed people better than brown-eyed people. We do not treat women better than men. We do not provide better care to blonde-haired people than red-haired people. Medical personnel see people at their most vulnerable; the trust placed in us is sacred. To tie an employer's hands, to not permit an employer to make respectful and equal treatment of all patients part of a job description, hurts patients by preventing them from accessing needed care even at trusted facilities and practices. If we at the LA LGBT Center need to provide care to the LGBT community, we cannot be forced to hire and continue working with someone who refuses to provide care to this community without violating the LA LGBT Center's mission, medical ethics, and established standards of care.

16. As LA LGBT Center's Co-Director of Health services, my responsibility includes enforcing our nondiscrimination mandate with respect to all of our providers and staff, including those working on federally funded research. I, therefore, have a reasonable fear that the ability to provide federally funded healthcare services and conduct federally funded research could be severely impeded, potentially putting patients and research participants at risk, if the Denial-of-Care Rule is allowed to take effect. I could also be subject to sanctions as someone who oversees the LA LGBT Center's clinical research.

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

Executed on September 9, 2019, in Los Angeles, California.

Ward Carpenter, MD

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA et al,,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C 19-02405 WHA
No. C 19-02769 WHA
No. C 19-02916 WHA

DECLARATION OF PETE CERVINKA IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

Date: October 30, 2019
Time: 8:00 AM
Dept: 12
Judge: Hon. William H. Alsup
Action Filed: 5/2/2019

I, Pete Cervinka, declare:

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

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

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

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

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

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

In-Home Supportive Services

7. The IHSS program is a Medicaid benefit program that provides in-home assistance to eligible aged, blind, and individuals with disabilities as an alternative to out-of-home care and enables recipients to remain safely in their own homes. The purpose of the program is to allow vulnerable elderly and disabled Californians to avoid costly and unnecessary institutionalized care and to receive necessary services in their homes and communities. IHSS services include: paramedical services; accompaniment to medical appointments; personal care such as bowel and bladder care, bathing, and certain medical services under the direction of a physician; domestic and related services such as meal preparation, housecleaning, laundry, and grocery shopping; and protective supervision. Over 502,000 IHSS providers are employed to provide services to more than 594,000 IHSS recipients. More than 98 percent of the IHSS recipient population receives IHSS as a Medi-Cal (Medicaid) benefit, for which CDSS will receive approximately $6 billion in federal funding for state fiscal year 2018-19.

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

Child Welfare and Foster Care Programs

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

system. Title IV-E funds, in conjunction with state and local funds, are used to provide monthly maintenance payments for the daily care and supervision of children in foster care; adoption assistance payments; kinship guardianship assistance payments; administrative costs of activities necessary to implement the program; training of staff and foster care providers; recruitment of foster parents; and costs related to the design, implementation and operation of a state-wide child welfare case management and data system. CDSS received approximately $2.2 billion in federal funding under Title IV-E in state fiscal year 2018-19.

10. Title IV-B provides funding for child welfare services that focus on the prevention of, and response to, child abuse and neglect. This funding supports services and programs which: 1) prevent the neglect, abuse, or exploitation of children [through the Child Abuse Prevention and Treatment Act program and the Community-Based Child Abuse Prevention program, for which CDSS received a combined $14.5 million in state fiscal year 2018-19]; 2) promote the safety, permanence and well-being of children in foster care and adoptive families, as well as to provide training, professional development and support to ensure a well-qualified workforce [for which CDSS received $29.2 million under Title IV-B Part I in state fiscal year 2018-19]; and 3) provides funding for states to operate coordinated child/family support and preservation services, and seeks to promote adoption and support services that prevent child maltreatment among at-risk families [through the Promoting Safe and Stable Families program, for which CDSS received $33.4 million for administrative and assistance payments in state fiscal year 2019]. Thus, CDSS received a total of $77.1 million dollars in federal funding for these programs.

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

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Refugee and Entrant Assistance

12. CDSS administers the Refugee Entrant Assistance program on behalf of the federal government. This program serves refugees and other eligible immigrants who do not qualify for Temporary Assistance for Needy Families, Supplemental Security Income, or Medicaid programs and meet the income and resource eligibility standards of the program. The purpose of this program is to assist refugees and other eligible immigrants, such as asylees, Cuban and Haitian entrants, Special Immigrant Visa arrivals, and trafficking victims, to become employed and self-sufficient as quickly as possible and to integrate successfully into their receiving communities. Under the program, refugees and eligible individuals can receive refugee cash assistance and refugee medical assistance during their first eight months in the US, as well as a broad range of social services intended to help refugees obtain employment, achieve economic self-sufficiency, and further their social integration. The refugee social services programs include programs for elder care, school impact services, youth mentoring programs, employment training and English language acquisition services. Service providers offer a range of support to eligible recipients to further their social integration, including counseling focused on communication, stress management, and conflict resolution; employment case management; interpretation and translation; assistance with citizenship and naturalization; and assistance in connecting with health care providers.

13. CDSS received approximately $21.6 million from the federal Refugee Entrant Assistance Grant in federal fiscal year 2018-19. The loss of this federal funding would have an immediate negative impact on newly arrived refugees and other eligible individuals and their families, who receive support and services during their first eight months in the United States. These initial few months are critical to vulnerable individuals, who are experiencing cultural acclimation and learning to navigate a new society. The loss of federal funding would impact supports that include cash aid, employment, medical, and language services that provide critical pathways to self-sufficiency and prevent increased poverty for this already vulnerable population.

Deaf Access Program

14. The Deaf Access Program was created in 1980 to ensure that California's public social service programs are able to meet the communication needs of deaf and hard of hearing children, adults, and families. Meeting the communication needs of this population assists them in achieving economic independence and in fully participating in society. The services provided by the Deaf Access Program include sign language interpretation, advocacy, job development and placement, counseling, information and referral and community education.

15. CDSS received approximately $3 million in state fiscal year 2019 and the loss of this federal funding would greatly reduce the above-noted services.

CDSS Potential Budgetary Consequences

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

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17. In developing its annual budgets, CDSS does so with the expectation that it will receive the federal funds which are put at risk under the Rule, and to which it is entitled to under its agreements with federal agencies and Congressional intent for these programs. The California state budget is developed in January, revised in May of each year, and enacted by the Legislature in July. The budget for programs administered by CDSS is based upon projected program caseload and expenditure trends and considers the availability of state revenues and anticipated federal funds. These federal and state resources are considered in the determination of baseline funding necessary for critical state and county program operations and in decision-making on major policy changes, investments, and priorities for the State. Once budget commitments are made and enacted through legislation, it is difficult for California counties to seek additional funding or redirect revenues to cover any shortfalls. The long-lasting negative impacts of funding reductions is devastating to counties, service providers, and the vulnerable program recipients. A sudden disruption in anticipated federal funds, should they be terminated in whole or in part due to the rule, would cause budgetary and operational chaos, in addition to the adverse human impacts noted above.

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

Executed on September 10, 2019, in Sacramento, California.

Pete Cervinka
Chief Deputy Director
California Department of Social Services

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA et al,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C19-02405 WHA
No. C19-02769 WHA
No. C 19-02916 WHA

DECLARATION OF RANDIE C. CHANCE, PH.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

Date: October 30, 2019
Time: 8:00 AM
Courtroom: 12
Judge: Hon. William H. Alsup
Action Filed: 5/2/2019

I, Randie C. Chance, Ph.D., declare:

1. I am over the age of eighteen. I have first-hand knowledge of the matters declared to herein, and am competent to testify as to those facts, except as to the matters declared to on the basis of information and belief and, as to those matters, I have a reasonable basis to believe them to be true.

2. I am the Director of the new Department of Justice Research Center (the Research Center) within the California Justice Information Services Division of the California Department of Justice (CA DOJ).

3. The Research Center provides several functions to improve the work of the CA DOJ. Among other things, the Research Center supports divisions with their mandated reports by providing guidance and expertise on the content and the display of data in these reports; provides empirical research to improve social science research cited in the CA DOJ's litigation, in the development of legislative and policy proposals and in review of our law enforcement practices; and provides research and reports on public policy issues confronting California that affect the work of the CA DOJ.

4. I have worked for the CA DOJ since 2014. Prior to my current appointment, I served as the CA DOJ's lead researcher on a wide variety of research topics such as police practices, racial profiling and stop data, and issues related to immigration. I have also been leading a research team working to release criminal justice data for public access, and process data requests in support of the research community. Previously, I was a Senior Associate with a consulting firm examining social issues through services such as program evaluation, statistical consulting, and survey design and research.

5. I completed my doctorate in Psychology with a focus on Applied Social Psychology and Diversity Issues at Southern Illinois University Carbondale. I received a master's degree in Experimental Psychology and bachelor's degree in Psychology from the California State University at San Marcos. I have been conducting research on social justice topics for nearly 15 years.

6. I have reviewed the final rule titled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," issued by the U.S. Department of Health and Human Services. 84 Fed. Reg. 23170 (May 21, 2019). The Rule states that HHS "received 343 complaints" "during FY 2018." *Id.* at 23229, 23245. It also states that HHS received "thirty-four complaints" "between November 2016 and January 2018." *Id.* at 23229.

7. In connection with this Rule, I reviewed the "343 Complaints referenced in the 2019 Final Rule, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority (Final Rule), 84 Fed. Reg. 23,170 (May 21, 2019), as listed at 000537745 – 000537752" (Bates numbers 000542017 – 000545608).

8. In total, I reviewed 687 files. The review of these files resulted in what we concluded to be 321 unique complaints. Duplicative documents were not counted as unique complaints. A document was considered duplicative if information on or about the document was identical to another document, including the party to which the document was sent and the complaining party. In other words, if one complaining party sent identical letters to multiple different recipients, each letter was counted as a unique complaint. However, if one complaining party sent an identical letter to an identical recipient, only one complaint was counted.

9. Complaints reviewed were submitted between April 2017 and September 2019. Eight (8) complaints were from 2017, 300 complaints were from 2018, and 13 complaints had no discernable date submitted. *See* Figures 1 and 2.

Figure 1. Number of Complaints Filed by Month from April 2017 to September 2018

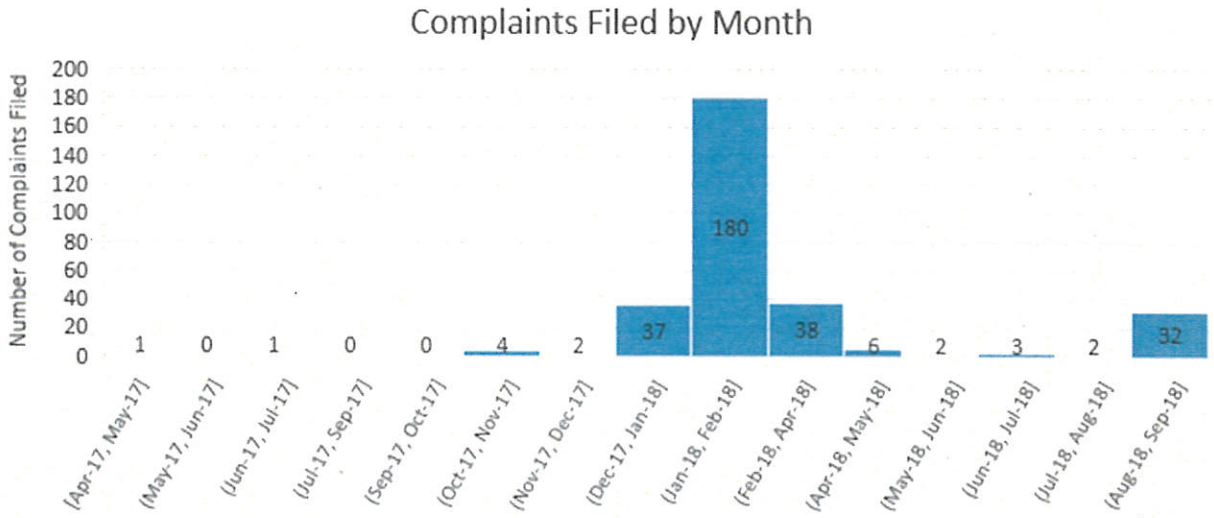
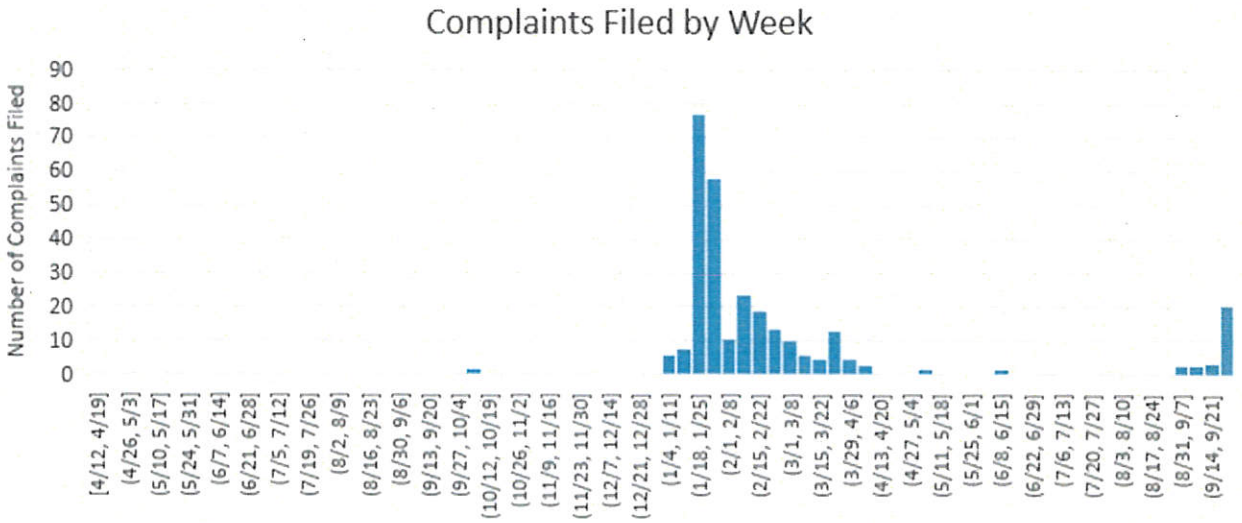


Figure 2. Number of Complaints Filed by Week from April 2017 to September 2018



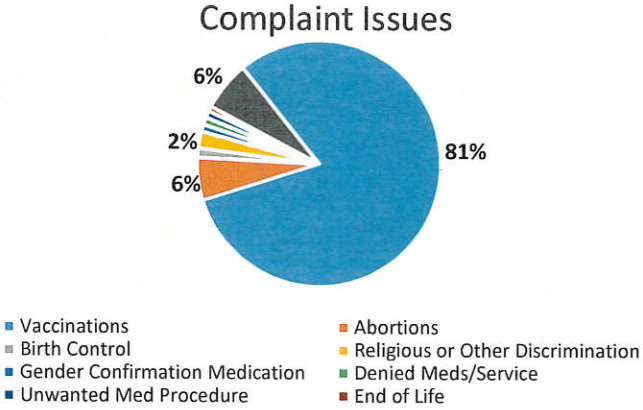
10. The type of issues raised in the complaints were coded as either (a) objection to vaccination, (b) objection to abortion[1], (c) objection to birth control (d) experienced religious or other forms of discrimination [e.g., racial, disability], (e) objection to gender confirmation medication, (f) denied requested medication or procedure, (g) received unwanted medical procedure [other than vaccine], (h) objections to end-of-life services, or (i) other/unknown.

11. The large majority of the complaints were regarding objections to vaccinations (81% of complaints), including state vaccination mandates, based on religious and other reasons. Objections to abortion made up only 6% of complaints (18 complaints). *See* Table 1 and Figure 3.

Table 1. Complaint Issue Count and Percentage

Complaint Issue	**Count**	**%**
Vaccinations	260	81%
Abortion	18	6%
Birth Control	4	1%
Religious or Other Discrimination	7	2%
Gender Confirmation Medication	3	1%
Denied Medication/Procedure	3	1%
Unwanted Medical Procedure	3	1%
Objects to End-of-Life Service	2	1%
Other/Unknown	21	6%
Total	321	100%

Figure 3. Complaint Issue Percentage



[1] Several objectors also filed complaints regarding "abortiofacent contraceptives." As the federal defendants have explained, while some individuals may regard certain methods of contraception as "causing abortion," "federal law, 'which define[s] pregnancy as beginning at implantation, do[es] not so classify them.'" *Zubik* Br., 2016 WL 537623, at *19 n.8 (quoting *Burwell v. Hobby Lobby, Inc.*, 573 U.S. 682, 698 (2014)). For purposes of my review, I have lumped these complaints together with the abortion complaints.

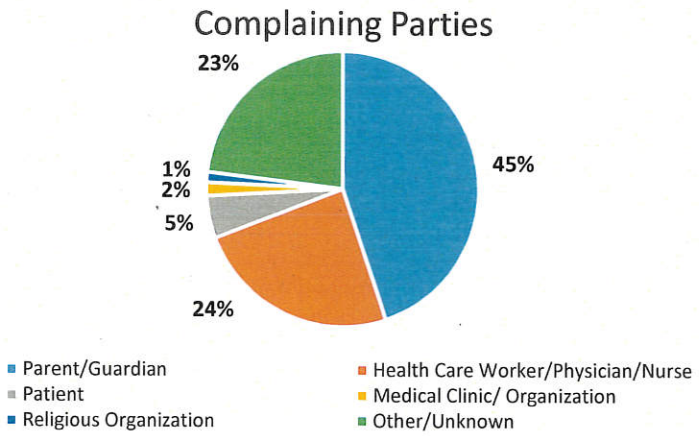
12. The identity of the complaining parties were coded as either (a) parent/guardian, (b) healthcare worker/physician/nurse, (c) patient, (d) medical clinic/organization, (e) religious organization [non-medical], or (f) other/unknown.

13. The majority of the complaints were brought by individual parents and/or guardians. Forty-five percent (45%) of complaints were made by a parent regarding their child and 24% of complaints were made by a physician, nurse, pharmacist, or other healthcare worker. *See* Table 2 and Figure 4.

Table 2. Complaining Parties Count and Percentage

Complaining Parties	**Count**	**%**
Parent/Guardian	144	45%
Healthcare Worker/Physician/ Nurse	78	24%
Patient	16	5%
Medical Clinic/ Organization	5	2%
Religious Organization	4	1%
Other/Unknown	7	23%
Total	321	100%

Figure 4. Complaining Parties Percentage



14. The location of where the events took place were coded as either (a) 'yes' if the event occurred in California or (b) 'no' if it was not. One-hundred twenty-two (122) complaints or 39% were regarding events in CA, 163 complaints (52%) were regarding other states, and 29 complaints (9%) did not specify location. Of the CA-specific complaints, 112 (92%) were

regarding objection to vaccination and mandatory vaccination laws, 5 (4%) were objections to abortion, and 5 (4%) were regarding other objections (e.g., birth control, end-of-life service, unwanted medical procedure).

15. I examined the complaints related to abortion. Eighteen (18) complaints of the 321 total complaints were regarding abortion-related topics. Seven (7) of these complaints (39%) were objections to health insurance companies covering abortions, 4 (22%) complaints were objecting having to provide information about abortion or refer patients to other clinics that perform abortion if the patient requested, 4 (22%) complaints were objecting to performing abortions, and 3 (17%) were for other abortion-related issues. Of these 18 complaints, 6 (33%) were made by healthcare workers, 4 (22%) complaints were made on behalf of religious organizations, 3 (17%) were made by pregnancy clinics, and 5 complaints (28%) were made by patients, general members of the public, or other parties.

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

Executed on September 4th, 2019, in Sacramento, California.

Randie C. Chance

Randie C. Chance, Ph.D.
Director, Research, Analysis, and Data Center
California Department of Justice