UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants,

DR. REGINA FROST and CHRISTIAN MEDICAL AND DENTAL ASSOCIATIONS,

Defendants-Intervenors.

Civil Action Nos.
1:19-cv-4676 (PAE) (lead)
1:19-cv-5433 (PAE) (consolidated)
1:19-cv-5435 (PAE) (consolidated)

REPLY MEMORANDUM IN SUPPORT OF PLAINTIFFS' CROSS-MOTION FOR SUMMARY JUDGMENT, IN OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

After two rounds of briefing, HHS has all but conceded that the Rule as written cannot stand. HHS offers no defense of the Rule's absolutist definition of "discrimination," which disregards the burdens on health care providers and jeopardizes their ability to deliver care. Instead, seeking to avoid judicial scrutiny, HHS tries to pretend the definition does not exist, insinuating that it *might*, in the future, *sometimes* go outside the Rule to recognize unwritten exceptions to the Rule's onerous and unprecedented requirements. But the agency still cannot provide a clear framework under which Plaintiffs can operate, and it never disclaims, *e.g.*, that the Rule prohibits reassignment of someone unwilling to perform core functions of their job, would hamstring providers from even asking a prospective employee whether they are willing to satisfy the job description, and require onerous double-staffing. HHS also reverses the position it took in the Rule's Preamble and insists that the Rule's enforcement scheme is lawful because it does not actually give HHS new enforcement tools. And having been caught in a falsehood—the repeated assertion in the proposed and Final Rule that there has been a "significant increase" in complaints of discrimination under the refusal statutes—HHS pretends that it never offered this provably untrue claim as a central justification for the Rule.

None of this changes the fact that the *real* Rule must fall. HHS still cannot point to statutory authority to rewrite the refusal statutes through interpretations intended to have the force of law. It cannot, and mostly does not try to, defend the Rule's actual definition of "discrimination" and its other interpretations. And it has no convincing response to the many other respects in which the Rule is contrary to law, other than to take contradictory positions that further prove the agency's action is arbitrary and capricious, too. The Rule should be set aside.

ARGUMENT[1]

I. The Rule Exceeds HHS's Statutory Authority in Violation of the APA

A. Congress Did Not Delegate Authority to HHS to Issue Interpretations of Church, Coats-Snowe, and Weldon with the Force of Law

The Rule creates new legal rights and obligations through its novel and strained interpretations of the underlying refusal statutes.[2] *See* Mem. Supp. Pls.' Cross-Mot. Summ. J. (Providers' SJ Br.) 8–9, ECF No. 184. Yet Congress did not delegate HHS the authority to issue any force of law rules administering or interpreting those statutes. That flaw defeats the Rule, and at a minimum precludes *Chevron* deference for these new interpretations.

HHS makes only a perfunctory, and ultimately unavailing, argument that "several statutes explicitly authorize HHS to issue the Rule." Defs.' Consolidated Reply Supp. Defs.' Mot. Summ. J. (HHS Reply Br.) 6, ECF No. 224. HHS lists a motley assortment of statutory provisions, *id.*, but cannot connect these provisions to Church, Coats-Snowe, or Weldon. For example, HHS fails to explain how a statute concerning the testing of "innovative payment and service delivery models" by the Centers for Medicare and Medicaid Services, 42 U.S.C. § 1315a (cited at HHS Reply Br. 6), is at all relevant to the authority claimed to issue binding interpretations of the refusal statutes. Neither does the agency explain what relevant authority concerning the refusal statutes it derives from a delegation to "the Surgeon General" to promulgate regulations "necessary to the administration of the [Public Health] Service," with a specification that this delegation includes matters such as "uniforms for employees." 42 U.S.C. § 216 (cited at HHS Reply Br. 6).[3] Such

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[1] Plaintiffs incorporate here Parts II.B., IV of the State Plaintiffs' Reply Memorandum of Law in Support of Cross-Motion for Summary Judgment (States' Reply Br.), filed today, ECF No. 232.

[2] Defendants-Intervenors believe it is "derisive" to use the term "refusal statutes." Mem. Law Opp'n Pls.' Cross-Mots. Summ. J. (Def.-Int. Reply Br.) 1, ECF No. 223. But that term is simply drawn from the statutes. *See, e.g.*, 42 U.S.C. § 300a-7 ("refus[al] to perform or assist in the performance").

[3] The other statutory provisions that HHS cites likewise come nowhere near explicit authority for the Rule. As previously explained, Congress's "designat[ion]" of HHS to "receive complaints of

strained attempts to identify statutory grounding for the Rule only underscore how far from its delegated authority HHS has strayed.

The agency also doubles down on its claim that the Rule is authorized by "housekeeping statutes." HHS Reply Br. 3, 6 (citing 5 U.S.C. § 301). Yet it has no response to the basic rule, noted by Plaintiffs, Providers' SJ Br. 8, that a housekeeping statute is not "an authorization for the promulgation of substantive rules." *U.S. ex rel. O'Keefe v. McDonnell Douglas Corp.*, 132 F.3d 1252, 1255 (8th Cir. 1998). HHS instead mischaracterizes Plaintiffs' argument as being that the housekeeping statutes do not authorize the rule "because the Rule is too broad." HHS Reply Br. 6. But Plaintiffs never argued that the Rule is too "broad" to constitute housekeeping. The problem is that it is too *substantive* to constitute housekeeping. Again, HHS insists that its interpretation of the refusal statutes should carry the force of law and bind third parties. *See* Providers' SJ Br. 9. That is not "housekeeping."

Having failed to identify any express delegation of authority to promulgate the Rule, HHS next claims "implicit delegation from the Federal Conscience Statutes themselves." HHS Reply Br. 7. This argument subverts fundamental principles of administrative law. Indeed, the cases HHS cites confirm the necessary predicate—which is lacking here—for such implied interpretive authority to exist: that Congress has "generally conferred authority" to "make rules carrying the force of law." *See id.* (quoting *United States v. Mead Corp.*, 533 U.S. 218, 229 (2001) and *Rotmi*

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discrimination" against healthcare entities related to end-of-life care, 42 U.S.C. § 18113, does not confer rulemaking authority concerning Church, Coats-Snowe, and Weldon. *See* Providers' SJ Br. 7–8. Nor is there anything delegating rulemaking authority over those statutes in the Affordable Care Act's provisions on state opt-out of abortion coverage and specific rules applicable to abortion coverage in qualified health plans, *see* 42 U.S.C. § 18023, or its provisions requiring HHS to issue regulations setting standards for the establishment and operation of healthcare exchanges, *see* 42 U.S.C. § 18041. The same is true of the statute requiring HHS to issue and renew medical laboratory operating certificates based on criteria such as which exams and methodologies the lab uses and qualifications of staff, *see* 42 U.S.C. § 263a, and the statutory requirement that HHS, the Secretary of Labor, and the Secretary of the Treasury conduct impact analyses for new rules, to study their potential effects on small rural hospitals. *See* 42 U.S.C. § 1302.

v. Gonzales, 473 F.3d 55, 57 (2d Cir. 2007)). HHS fails to engage with the basic problem that it has been delegated *no* rulemaking authority, general or otherwise, with respect to Church, Coats-Snowe, and Weldon. And it does not explain why it should have greater authority over these statutes than, for example, the EEOC has when it enforces Title VII. As Plaintiffs explained, Providers' SJ Br. 10–11, the EEOC is inarguably charged with enforcing Title VII, yet its interpretations of that statute have not been granted *Chevron* deference because its "congressional delegation did not include the power to 'promulgate rules or regulations.'" *Mead Corp.*, 533 U.S. at 229 (citing and quoting *EEOC v. Arabian Am. Oil Co.*, 499 U.S. 244, 257 (1991)). The same can be said of HHS and the statutes at issue here.

Rather than confront this problem, the agency attempts to support its argument with Supreme Court decisions it misconstrues. First, HHS badly misreads *Gonzales v. Oregon*, which closely analyzed a statutory delegation of authority, found that it did not encompass the question on which the Attorney General had attempted to regulate, and concluded that the statute "does not give the Attorney General authority to issue [an] Interpretive Rule as a statement with the force of law." 546 U.S. 243, 268 (2006). HHS claims that this result had to do with the Attorney General's lack of consultation beyond his Department. HHS Reply Br. 10. Yet the Court simply mentioned this in passing in its factual exposition. *See Gonzales*, 546 U.S. at 253. Similarly, HHS points to the Court's observation that the agency "failed to follow certain procedures." HHS Reply Br. 10. But the reason the Attorney General did not follow "the required procedures for rules regarding scheduling" was that "[t]he Interpretive Rule now under consideration does not concern the scheduling of substances." *Gonzales*, 546 U.S. at 260. In other words, the procedural point simply confirmed that the Attorney General was acting outside of the delegation he was attempting to invoke. This meager effort to distinguish *Gonzales* does not undermine its clear import: "[a] rule

must be promulgated pursuant to authority Congress has delegated to the official," *id.* at 258; here, there is none.

Otherwise ignoring *Gonzales* because it is fatal to its claim of authority, HHS focuses instead on *Barnhart v. Walton*, 535 U.S. 212, 222 (2002), but misreads that case as well. Citing *Barnhart*, HHS asserts that "[t]o determine *whether Congress has implicitly delegated authority* [to an agency], courts consider" various factors, such as the longstanding nature of the interpretation and the interstitial character of the issue. HHS Reply Br. 7 (emphasis added). This is simply not what *Barnhart* says nor how courts consider the implicit delegation question.

The Supreme Court has identified two distinct questions: (1) whether "it appears that Congress delegated authority to the agency generally to make rules carrying the force of law," and (2), if so, whether "the agency interpretation claiming deference was promulgated in the exercise of that authority." *Mead*, 533 U.S. at 226–27. This case is resolved by the first question, because there is absolutely no indication in the text of Church, Coats-Snowe, or Weldon that HHS was "delegated authority" to "make rules carrying the force of law." In *Barnhart*, by contrast, there indisputably was such a delegation: the agency was "[a]cting pursuant to statutory rulemaking authority." *Barnhart*, 535 U.S. at 217. It was the second question that was at issue in that case. In particular, the agency had adopted the challenged interpretation informally over many years, and "only recently" codified it through rulemaking. *Id.* at 221. The factors invoked by HHS here—"the interstitial nature of the legal question, the related experience of the Agency, the importance of the question to administration of the statute, the complexity of that administration, and the careful consideration the Agency has given the question over a long period of time"—helped overcome the lack of formal procedures giving rise to the interpretation. *Id.* at 222. But the mere

"interstitial" nature of a question cannot override the lack of any delegation of rulemaking authority at all, and nothing in *Barnhart* holds otherwise.[4]

For all of these reasons, HHS lacks authority to issue this Rule, a central feature of which is to expand the reach of the refusal statutes with unprecedented "definitions." Neither housekeeping authorities nor the mere existence of the refusal statutes "give[s] [HHS] authority to issue the [Rule] as a statement with the force of law." *Gonzales*, 546 U.S. at 268. But even if the Rule were understood not as an assertion of substantive regulatory authority, but instead merely to "provide[] guidance on how HHS defines key terms," HHS Reply Br. 6, it would at a minimum plainly not be entitled to *Chevron* deference. *See Gonzales*, 546 U.S. at 268 (explaining that if the analysis in the Interpretive Rule were used "only for guidance," it would "not receive *Chevron* deference" because it was "not promulgated pursuant to the Attorney General's authority"); *Cruz-Miguel v. Holder*, 650 F.3d 189 (2d Cir. 2011) ("internal guidance documents" are "generally unworthy of *Chevron*-style deference"). Contrary to HHS's suggestions, *Chevron* deference "is not accorded merely because the statute is ambiguous and an administrative official is involved. To begin with, the rule must be promulgated *pursuant to authority Congress has delegated to the official*." *Gonzales*, 546 U.S. at 258 (emphasis added). Indeed, it is "[a] precondition to deference under *Chevron*" that there be "a congressional delegation of administrative authority." *Adams*

[4] Even if the *Barnhart* analysis applies here it would not help HHS. In *Barnhart*, the Court found that the "long period of time" the agency had considered the issue in question was a period of nearly fifty years. *Barnhart*, 535 U.S. at 219–20. Here, the Church Amendments were enacted in the 1970s, Coats-Snowe in 1996, and Weldon in 2005, but HHS did not issue any rule interpreting these laws until late 2008, which HHS proposed to rescind shortly thereafter, and whose substantive interpretations were formally repealed in 2011, *see e.g.*, 74 Fed. Reg. 10,207 (Mar. 10, 2009; 76 Fed. Reg. 9,968 (Feb. 23, 2011); Joint Mem. Law Support Pls.' Mot. Prelim. Inj. ("Providers' PI Br.") 4–5, ECF No. 20 (No. 1:19-cv-5433) (explaining 2008 rulemaking)—and did not attempt rulemaking again until proposing the current interpretation in 2018. Moreover, as Plaintiffs have explained, the Rule raises issues of weighty social importance, and has been described by the President as creating "new" legal rights. *See* Providers' SJ Br. 9. These questions are hardly "interstitial in nature," *Barnhart*, 535 U.S. at 222.

Fruit Co., Inc. v. Barrett, 494 U.S. 638, 649 (1990). The Supreme Court has been clear: an agency that is not authorized "to make rules with the force of law" does not receive *Chevron* deference. *Mead*, 533 U.S. at 237.

HHS misunderstands Plaintiffs' argument as asserting "*Chevron* deference is unavailable to an agency when other agencies also administer the same statute." HHS Reply Br. 9. Plaintiffs' actual point—for which HHS simply has no response—is that Church, Coats-Snowe, and Weldon are not directed to any agency to administer *at all*. Providers' SJ Br. 11–12.[5] Thus, HHS's example of the Clean Air Act, in which Congress clearly delegated authority to the EPA to issue regulations carrying the force of law, *see, e.g.*, 42 U.S.C. § 7409(a), while also recognizing a role for states to play in the statutory scheme, is wholly inapposite. Here, because the relevant statutes are not within its "special charge to administer," they are not entitled to *Chevron* deference. *Prof'l Reactor Operator Soc'y v. U.S. Nuclear Regulatory Comm'n*, 939 F.2d 1047, 1051 (D.C. Cir. 1991).

B. Congress Did Not Delegate the Broad New Enforcement Authority that HHS Claims For Itself in the Rule

In stark contrast to other statutes that OCR enforces, *see, e.g.*, Title VI of the Civil Rights Act, 42 U.S.C. § 2000d-1, nothing in the refusal statutes expressly delegates to HHS the breathtaking enforcement power it arrogates to itself in the Rule. Recognizing this, HHS tries to recharacterize the plain language of the Rule to minimize the scope of its enforcement provisions. *See* HHS Reply Br. 3–5. HHS now claims that the Rule's enforcement provisions are limited to and extend no further than the mechanisms set forth in existing regulations governing federal awards. *Id.* Yet, as discussed *infra* and in the Provider Plaintiffs' opening briefs, Providers' SJ Br.

[5] HHS suggests that different interpretations could control "when another agency disburses funds governed by the Federal Conscience Statutes." HHS Reply Br. 9–10. It would be exceedingly odd for Congress, without appearing to delegate rulemaking authority to any agency at all, to create a situation in which differing interpretations of the same statutes could have the force of law at the same time.

13–14, Providers' PI Br. 14–16, the enforcement mechanisms set forth in the Rule are on their face not so circumscribed. On the contrary, they contemplate draconian new remedies for noncompliance that do not exist in the regulations HHS now cites, including the HHS Uniform Administrative Requirements ("UAR"), 45 C.F.R. Part 75, §§ 75.371–75.374. *See* Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23,170, 23,271–72 (May 21 2019) (§ 88.7).[6] Indeed, at the same time that HHS's counsel insists that the Rule creates no new regulatory enforcement mechanisms, the agency continues to assert that the Rule remedies what HHS considered to be "inadequate enforcement tools." 84 Fed. Reg. 23,228; HHS Reply Br. 24–27; Defs.' Consolidated Mem. Law Supp. Defs.' Mot. Summ. J. (HHS SJ Br.) 13, 14, 53, ECF No. 148.[7] Defendants cannot have it both ways.

Plaintiffs do not "imagine" contradictions between the Rule's enforcement mechanisms and those set forth in the HHS UAR. HHS Reply Br. 4. A comparison of the text of the Rule and the UAR illustrates them.[8] For example, the Rule explicitly warns that OCR may attempt "funding claw backs," 84 Fed. Reg. 23,180, an extreme remedy that is not available under the UAR, 45

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[6] HHS sends this Court (and Plaintiffs) through a morass of regulations that it claims already allow it to enforce the refusal statutes. *See, e.g.*, HHS Reply Br. 9–11, 23. In particular, HHS claims it has authority to enforce violations of the refusal statutes in federal contracts under the Federal Acquisition Regulation (FAR), C.F.R. tit. 48 and HHS Acquisition Regulation, HHSAR, 48 C.F.R. Ch. 3, as well as the UAR. As a threshold matter, the FAR and HHSAR apply only to "acquisition" contracts; *not* to all federal contracts. 48 C.F.R. §§ 1.103, 2.101. And, on closer inspection, it is not at all clear from any of the provisions HHS cites that OCR can terminate a federal acquisition contract by default (*i.e.* for cause) or debar a contractor from federal procurement due to violations of the refusal statutes. *See, e.g.*, 48 C.F.R. § 352.270–9 (attaching conditions to HIV/AIDS prevention funds).

[7] For example, in its reply brief, HHS repeats the argument that the Rule is not arbitrary and capricious because the enforcement authority under the 2011 Rule was too narrow and "OCR needs more tools to better ensure compliance with the Statutes' conditions on HHS's funding." HHS Reply Br. 24–27; *see also* Providers' SJ Br. 12–13; 84 Fed. Reg. 23,228. And HHS has likewise stated that the Rule's enforcement tools are intended to create "incentives" for third parties to take "proactive measures" they otherwise would not take. 84 Fed. Reg. 23,228.

[8] As Plaintiffs explained in prior briefing, the Rule also goes further than the civil rights statutes OCR enforces, which contain carefully drawn enforcement schemes with explicit due process protections for funding recipients. *See* Providers' SJ Br. 14–15 & n.5 (discussing enforcement mechanisms in Title VI, Title IX, the Age Discrimination Act, the Rehabilitation Act, and Section 1557 of the ACA).

C.F.R. § 75.371. The UAR permits the HHS awarding agency to suspend or terminate only the particular "*Federal award*" at issue, *id.* at § 75.371(c), disallow only the "*cost of the activity or action not in compliance*," *id.* at § 75.371(b), or withhold further federal awards only "*for the project or program*" at issue, *id.* at § 75.371(e) (emphases added). By contrast, the Rule allows OCR, in "coordination with the funding component," to terminate *all* federal funds administered by HHS, 84 Fed. Reg. 23,272 (§ 87.1(i)(3)).[9]

As another example, under the Rule, recipients may be liable for violations of their subrecipients, meaning that both the recipient *and its other subrecipients* risk losing HHS funding because OCR has found a single subrecipient in violation. *See* 84 Fed. Reg. 23,270 (§ 88.6); *see also* Compl. Declaratory & Injunctive Relief (NFPRHA Compl.) ¶ 117, ECF No. 1 (No. 1:19-cv-5435). No similar provision exists in the UAR. *Compare* 45 C.F.R. § 75.352 (requiring pass-through entities to monitor subrecipients but stopping short of holding them liable for subrecipient violations, let alone penalizing all other subrecipients in the process).

The UAR also provides detailed due process protections for funding recipients that are not explicitly replicated in the Rule.[10] Under the UAR, the HHS awarding agency may only pursue more aggressive remedies if it determines that noncompliance cannot be remedied by imposing additional conditions. 45 C.F.R. § 75.371. The Rule, by contrast, expressly reserves the right to

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[9] And in any event, as the State Plaintiffs explain, *see* States' SJ Br. 42–46, termination of all HHS funds would unquestionably constitute a violation of the Spending Clause under *Nat'l Fed'n of Indep. Business v. Sebelius*, 567 U.S. 519 (2012).

[10] Even if OCR could use the FAR to enforce the refusal statutes, the FAR provision HHS cites for debarring contractors, *see* HHS SJ Br. 23, provides rigorous due process requirements. 48 C.F.R. § 9.406-3. And before a contract may be terminated for default for failing to perform a provision of the contract—a remedy available only when termination is actually in the best interest of the government, 48 C.F.R. § 49.101(b)—the contracting officer must provide notice, an opportunity to cure, and the right to appeal. 48 C.F.R. §§ 49.402–3; 52.249–8, 52.249–9. And, as a general matter, it is "well settled that default-termination is a drastic sanction, which should be imposed (or sustained) only for good grounds and on solid evidence." *See Lisbon Contractors, Inc. v. United States*, 828 F.2d 759, 765 (Fed. Cir. 1987).

undertake involuntary enforcement measures even during the pendency of good faith, voluntary compliance efforts. 84 Fed. Reg. 23,271–72 (§ 88.7(i)(2)). Before taking any remedy for non-compliance, the UAR requires the HHS awarding agency to provide the funding recipient "an opportunity to object and provide information and documentation challenging the suspension or termination action," as well as any "hearings, appeals or other administrative proceedings" to which the entity is otherwise entitled, incorporating procedures under, *inter alia*, the Public Health Service Appeals Procedures, 42 C.F.R. Part 50, and the Procedures of the Departmental Appeals Board, 45 C.F.R. Part 16. *See* 45 C.F.R. § 75.374. Although the Rule cursorily states that compliance will be effectuated "pursuant to," regulations including the UAR, 84 Fed. Reg. 23,272 (§ 88.7(i)(3)), this passing reference does not say that the Rule's enforcement mechanisms are "limited to" those existing regulations, nor does it unambiguously incorporate the UAR's due process protections into the Rule's enforcement scheme.[11] This is particularly notable given that the Rule proceeds to spell out the remedial actions OCR may take without also including those due process protections. *Id.*

HHS's attempt to constrain the Rule's enforcement provisions to existing regulations is understandable, but still unavailing. As Plaintiffs have repeatedly stated, this case does not contest HHS's basic authority to evaluate compliance with the federal refusal statutes as provided for in the 2011 Rule. *See* Providers' SJ Br. 16; Providers' PI Br. 15. Plaintiffs agree that this may include use of other existing regulatory enforcement mechanisms, such as the UAR, where applicable. However, where, as described above, an agency assumes unprecedented new powers that impose significant burdens on third parties, it must invoke some delegation of authority from Congress,

[11] The Rule also states compliance will be effected "pursuant to" "CMS funding arrangements (e.g., the Social Security Act)." 84 Fed. Reg. 23,272 (§ 88.7(i)(3)). But HHS does not mention CMS funding arrangements in its briefs, let alone provide any citation to the enforcement procedures OCR would use before terminating CMS funds for violation of the refusal statutes.

and such "authority may not be lightly presumed." *Atl. City Elec. Co. v. FERC,* 295 F.3d 1, 9 (D.C. Cir. 2002) ("Were courts to *presume* a delegation of power absent an express *withholding* of such power, agencies would enjoy virtually limitless hegemony." (citation omitted)). Moreover, as HHS's own argument makes clear, the Rule is not needed to enforce the refusal statutes because existing regulatory authorities, such as the UAR, provide mechanisms for ensuring grant-recipients comply with their legal obligations. *See also* States' Reply Br. 12–13 (ECF No. 232). Because HHS cannot point to any delegation of authority for the broad new enforcement power it actually assumes in the Rule's plain text, the Rule exceeds statutory authority and must be set aside.

II. Defendants Failed to Rebut Plaintiffs' Showing that the Rule Is Contrary to Law

A. Defendants Cannot Rewrite the Rule's Definition of Discrimination

Central to Defendants' reply brief is a desperate attempt to reframe Plaintiffs' challenge to the Rule as a challenge to the underlying statutes, and, equally misguidedly, to rewrite the Rule to be less extreme than it actually is. Neither argument is successful.

First, this litigation does not challenge the underlying statutes. Plaintiffs have been clear from the outset that they seek to set aside the Rule because it unlawfully expands the underlying statutes in numerous ways—including by expanding the type of individuals and entities that may refuse to provide certain services; by expanding the type of services that individuals and entities may refuse to provide; and by imposing severe and unprecedented obligations on a covered entity required to comply with the Rule. *See* Providers' PI Br. 27–31; Providers' SJ Br. 16–28. As HHS is well aware, Plaintiffs brought a claim that the Rule is contrary to law because it seeks to define key terms, such as "discrimination" or "discriminate," in ways that do not comport with the underlying statutes. *See id.* If HHS is confused about "how [Plaintiffs] believe the challenged Rule meaningfully differs from the Federal Conscience Statutes," HHS Reply Br. 1, it is only because, as discussed *infra*, they ignore the plain language of the Rule.

Second, presumably because HHS has recognized how far afield it has strayed from the underlying statutes, HHS now seeks to walk back the unprecedented obligations the Rule imposes on health care providers through the definitions of "discrimination" or "discriminate," arguing for the first time that the Rule does not *always* require Plaintiffs (and other health care providers subject to the Rule) to accommodate employees who refuse to provide certain health services and information to their patients. HHS Reply Br. 12–13. Indeed, HHS now submits that "the definition [of discrimination] simply provides examples of what *might* constitute discrimination," *id.* at 12—in other words, that it is not a "definition" at all. However, a review of the terms of the Rule makes clear that the definition of "discrimination" is far more extreme than the agency's counsel represents in its briefing.

Subsections (1) to (3) of the definition of "discrimination" provide a robust and "non-exhaustive," *id.* at 13, list of the types of action that constitute "discrimination," which includes, for example, "[t]o withhold, reduce, exclude from, terminate, restrict, or make unavailable or deny any . . . employment, title, . . . position, or status[,] . . . benefit or privilege or impose any penalty." 84 Fed. Reg. 23,263. The only logical reading of the Rule is that if a health care provider takes any of these actions against an individual who refuses to provide certain services or information (assuming that the health care provider, employee and objected-to services or information all are subject to the Rule), the Rule, by its terms, constitutes such action to be "discrimination." Subsection (4) then provides a limited exception, stating: "[n]otwithstanding paragraphs (1) through (3) of this definition," a health care provider "shall not be regarded as having engaged in discrimination" where it "offers *and the protected entity voluntarily accepts* an effective accommodation for the exercise of such protected entity's protected conduct, religious beliefs, or

moral convictions." *Id.* (emphasis added). That is the sole extent of the exception for an "effective accommodation" under the Rule.[12]

Thus, contrary to what HHS now argues, the Rule is clear that the only option a health care provider has when faced with an employee who refuses to provide a covered health service or information is to offer an "effective accommodation" that the employee "voluntarily accepts"; but if the employee does not accept, which they are under no obligation to do, the employer cannot take any of the actions outlined in subsections (1) to (3), as the only exception in the Rule is to offer an "effective accommodation" that is "voluntarily accepted." *See* 84 Fed. Reg. 23,263 (§ 88.2). For HHS to say that "it does not follow that *offering* an accommodation that is not accepted means that discrimination has occurred," HHS Reply Br. 12 (emphasis added), is mere sophistry.[13] The Rule is clear that there are two steps to "effective accommodation": (1) offer and

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[12] Separately, subsection (6) of the definition of "discrimination" explains that "[t]he taking of steps by an entity subject to prohibitions in this part to use alternate staff or methods to provide or further any objected-to conduct . . . would not, by itself, constitute discrimination . . . if such entity does not require any additional action by, or does not take any adverse action against, the objecting protected entity . . . and if such methods do not exclude protected entities from fields of practice." 84 Fed. Reg. 23,263. Thus, the Rule permits an employer to require *other staff* to perform the duties an objecting employee refuses to perform, but *only* if that cannot be construed as an "adverse action" against the employee and *only if* it does not result in the transfer of the employee into another "field of practice." *Id.*; *see also infra* Part II.C.1. (discussing *Shelton v. Univ. of Med. & Dentistry of N.J.*, 223 F.3d 220, 228 (7th Cir. 2000)).

[13] In arguing that the Rule allows more flexibility for employers to take into account the surrounding "facts and circumstances" in deciding whether and to what extent to accommodate employee objections, HHS Reply Br. 12–13, HHS misapplies a statement made in the preamble to the Rule, which addressed an entirely different issue. The language HHS relies on stems from concerns raised by commenters that "[t]he proposed definition of 'discriminate or discrimination' would turn *any* adverse action taken against a protected party for *any* reason into per se unlawful discrimination," 84 Fed. Reg. 23,192 (emphasis added), even if the objected to conduct was not protected by the refusal statutes. In response, HHS stated:

> The definition of "discriminate or discrimination" does not trigger violations based on any adverse action whatsoever, but must be read in the context of each underlying statute at issue, any other related provisions of the rule, and the facts and circumstances. In this rule, the prohibition on discrimination is always conditioned on, and applied in the context of, violating a specific right or protection, and each protected right is typically associated with a particular Federal funding stream or streams.

Id. Thus, the statement that it will depend on "the facts and circumstances" was referring solely to whether, *e.g.*, an entity that does not receive a grant under the Public Health Service Act could be bound by subsection

(2) voluntary acceptance, leaving no doubt that if an offer of accommodation is *not* voluntarily accepted, it does not constitute an "effective accommodation." In this critical way, the Rule gives employees an absolute right to veto an offered accommodation and leaves an employer with no recourse, regardless of the hardship it imposes on a health care employer's ability to provide care to its patients. Thus, if anyone is misreading and mischaracterizing the definition of "discrimination" as set forth in the Rule, it is HHS not Plaintiffs.[14] *See* HHS Reply Br. 12–13. Defendants' new argument that the Rule permits employers in some circumstances to refuse to accommodate certain employee objections, or allows employers to require employees to accept certain accommodations (that the employer deems reasonable) as a condition of maintaining their employment, not only conflicts with the text of the Rule, *supra*, but is also belied by Defendants' insistence that the Rule must abandon Title VII's reasonable accommodation / undue hardship framework because that framework is inconsistent with Congressional intent. HHS SJ Br. 32–33; *see also* Def.-Int. Reply Br. 5 ("Congress could reasonably have decided that, regardless of the burden on the employer, it is *never* acceptable to force healthcare professionals to choose between participating in procedures that violate their religious beliefs and losing their jobs."). Indeed, the

(c)(1) of the Church Amendments—not the limits of the Rule's "voluntary accept[ance of an] effective accommodation" exception.

[14] Defendants-Intervenors similarly misconstrue the terms of the Rule in an effort to make the Rule seem less onerous. Defendants-Intervenors focus on the last two sentences of subsection (4) of the definition of "discrimination" and claim that "the rule directs the Office of Civil Rights to 'take into account the degree to which an entity had implemented policies to provide effective accommodations for the exercise of protected conduct . . . and whether or not the entity took any adverse action against a protected entity *before* the provision of any accommodation." Def.-Int. Reply Br. 4 (quoting subsection (4) of definition of "discrimination). But this language reflects that even where an entity offers an effective accommodation that is voluntary accepted, this "will not, by itself, constitute discrimination," HHS Reply Br. 12 (quoting 84 Fed. Reg. 23,191). In other words, subsection (4) still allows HHS to review whether, prior to an employee's acceptance of an offered accommodation, the employer took adverse action against the employee and allows HHS to review the employer's policies. In no way does the language in subsection (4) address whether HHS can consider other factors when an employer takes adverse action against an employee after the employee refuses to accept an offered accommodation. Indeed, not even HHS claims that subsection (4) is the source of its discretion.

Preamble to the Rule makes clear that the very purpose of subsection (4) of the definition—which unequivocally requires accommodations to be voluntarily accepted—was to "address" the issue of "staffing arrangements" and delineate what would be "acceptable accommodations" in that context. 84 Fed. Reg. 23,191.

But even if counsel's new reading of the Rule were correct, it would not alleviate the extreme burdens the Rule imposes. Far from HHS's assertion that the Rule is necessary to "ensure knowledge of, [and] compliance with" federal refusal laws, *id.* at 23,175, HHS counsel advances a reading of the Rule that would provide no clear standard or framework under which a health care provider can ensure they do not run afoul of the Rule. Rather, HHS would have the discretion to determine—after the fact—whether a provider's refusal to provide an "effective accommodation" was or was not "discrimination," and HHS would simply know it when it sees it. *See* HHS Reply Br. 12–13 ("Subsection 4 simply identifies certain conduct that does not constitute discrimination, but whether the converse constitutes discrimination depends on," *inter alia*, "the facts and circumstances."). Moreover, when HHS tells employers after the fact that they have committed discrimination, it will no doubt claim deference for its interpretation of the Rule. *See Kisor v. Wilkie*, 139 S. Ct. 2400 (2019). Post-hoc determinations as to whether Plaintiffs and other providers engaged in discrimination based on unidentified criteria—of which Plaintiffs can only be certain is *different* than the reasonable accommodation / undue hardship framework—would leave providers in an impossible situation, not knowing whether taking certain action could lead to a finding of noncompliance and the loss of federal funding. The practical result is that for Plaintiffs and other providers who do not wish to jeopardize their federal funding, the Rule would operate just as Plaintiffs have explained: requiring health care providers to take *all* steps—even

unreasonable ones that unduly burden the ability to deliver care—to accommodate an employee who refuses to provide certain services to patients.

B. The Rule Is Contrary to the Underlying Refusal Statutes

Plaintiffs have identified four key terms in the Rule that unlawfully amend and expand the statutes they purport to implement. HHS insists that *Chevron* deference applies, HHS Reply Br. 6–10, but for all the reasons explained above and in prior briefing, *Chevron* deference is improper where, as here, the agency has not been delegated the authority to make rules carrying the force of law concerning the statutes at issue. But if this Court were to accord *Chevron* deference, HHS's interpretations would still fail. *See* Providers' SJ Br. 17. Moreover, even if *Chevron* applied, the agency would still be constrained in its interpretive choices: it may not adopt an interpretation that raises serious constitutional issues, *see* Providers' SJ Br. 19, or one that is barred by other statutes, such as Section 1554 of the Affordable Care Act, *see infra* Part II.C.2.

1. "Discrimination" or "discriminate". As Plaintiffs have explained in prior briefing, the Rule's definition of "discriminate" or "discrimination" is a drastic departure from the underlying statutes and how Congress must have intended the term to apply. In their reply brief, Defendants fail to meaningfully respond to Plaintiff's numerous arguments that the Rule is entirely inconsistent with the plain meaning of "discrimination."[15]

For one, Defendants do not grapple with the D.C. Circuit's holding, in addressing the Weldon Amendment, that it would be "anomalous" to "equat[e] . . . reassignment with discrimination," *Nat'l Family Planning & Reprod. Health Ass'n, Inc. v. Gonzales*, 468 F.3d 826, 829–30 (D.C. Cir. 2006) (*NFPRHA*). HHS's only apparent response is its new argument that the

[15] HHS also does not even attempt to respond to Plaintiffs' showing that the Final Rule's definition of "discrimination" or "discriminate" was not a logical outgrowth of the Proposed Rule and improperly enacted without notice and comment. *See* Providers' SJ Br. 48–53.

Rule contains a vague, standardless exception to its definition of "discrimination," which could sometimes, but not always, allow for reassignment even when the employee does not voluntarily accept reassignment. *See* HHS Reply Br. 12. Even if this strained reading were accepted in place of the Rule's plain text (which it cannot be, *see supra*), and even if health care providers were able to operate under Defendants' "maybe it is, maybe it's not, we'll let you know after the fact" approach to assessing claims of discrimination, Defendants' litigation-developed version of the definition still fails. At most, Defendants are only suggesting that in some undefined, limited circumstances (but not because an undue hardship exists), it *might* be okay for a health care provider to reassign an objecting employee without the employee's approval. This argument stops well short of disavowing that under the Rule, it could be "discrimination" to reassign an objecting employee to a different position without the employee's approval. This is directly contrary to the D.C. Circuit's conclusion that "an accommodating agency's reassignment" could *never* be "transform[ed]" into an "act of discrimination." *NFPRHA*, 468 F.3d at 830.

Second, Defendants avoid Plaintiffs' point that the Rule's framework is fatally at odds with how the term "discrimination" has been understood for decades when it comes to religious discrimination. Indeed, HHS's argument concerning Title VII is entirely ahistorical. When Congress originally passed Title VII, it banned "discrimination" generally without creating any explicit framework for assessing whether and to what extent employers were required to accommodate employees' religious objections. Over the next several years, a legal debate emerged between (1) whether Title VII required employers to make accommodations for employees with religious objections so long as those accommodations did not impose "undue hardship" on the employer, or (2) whether the failure to make any such accommodations was religious discrimination within the meaning of Title VII at all. *See Trans World Airlines, Inc. v. Hardison*,

432 U.S. 63, 71–76 (1977). Congress resolved this debate in 1972 by codifying the reasonable accommodation / undue hardship framework that some, including the EEOC, had already read into the concept of "discrimination." *See id.* at 73–74. But what was never suggested was a third option under which the duty not to discriminate on the basis of religious belief meant an *unlimited* obligation to accommodate, whatever the hardship to employers. It would have been shocking to the Congress that enacted the first Church Amendment in 1973 for "discrimination" to be interpreted as requiring accommodations irrespective of burden.

Lastly, Defendants do not even attempt to explain their contradictory reasoning for incorporating "components" of Title VII's accommodation framework into the Rule (*see* 84 Fed. Reg. 23,191), even though the underlying statutes do not expressly include these elements, while at the same time claiming that the undue hardship framework would be inconsistent with the underlying statutes solely because the underlying statutes do not expressly include it (*see id.*). *See* HHS SJ Br. 59. Indeed, Defendants' reasoning has become even more arbitrary and nonsensical now that Defendants assert that the Rule contains a newfound, undefined exception that may allow employers to refuse to accommodate an employee's objection in some circumstances. "Congress did not adopt such an exception in the applicable statutes," *id.* at 56, either. Defendants cannot have it both ways.

2. "Assist in the performance". HHS, again, deflects from Plaintiffs' real arguments, and misconstrues Plaintiffs' position on the meaning of "assist in the performance." *See* HHS Reply Br. 10 (claiming that Plaintiffs raise "that the Church Amendments are limited . . . to 'the actual performance' . . . of an abortion or sterilization procedure"). Plaintiffs have not argued that the underlying statutes only cover an individual that is actually performing an abortion; Plaintiffs have been clear that the statute plainly also extends to when an individual "*assist[s] in* the performance."

See Providers' SJ Br. 22 ("Congress was focused on the actual performance, i.e. execution, of an abortion or sterilization procedure—whether directly *or its assistance thereof* . . . .") (emphasis added). It is HHS that seeks to read words out of the statute by proposing a definition that is so broad that it would apply to scenarios even where no abortion is being performed (by anyone) or is ever performed. But the statute is clear that what an individual must be "assist[ing] in" is the actual "performance of an abortion."

As Plaintiffs have previously explained, Providers' PI Br. 27–28; Providers' SJ Br. 22, the Rule's definition of "assist in the performance" is so broad that it would allow an individual to withhold any information they believe might "aid" an individual obtaining an abortion, such as honestly answering a patient's question as to whether abortion is a legal option. 84 Fed. Reg. 23,188. Defendants dismiss Plaintiffs' example as "far-fetched," Def.-Int. Reply Br. 8, and as having "no basis in the Rule," HHS Reply Br. 11. However, in the preamble to the Rule, HHS expressly acknowledges that commenters raised this very concern. *See* 84 Fed. Reg. 23,188–89. And HHS confirmed that "assist in the performance" could mean anything so long as "aid is provided by such actions." *Id.* at 23,189. Once again, HHS cannot save the Rule by adopting more reasonable, litigation-developed positions that conflict with the plain language of the Rule.

3. <u>"Referral" or "Refer for".</u> HHS throws up even more smoke and mirrors in response to Plaintiffs' argument that the Rule's definition of "referral" / "refer for" exceeds the underlying statutes. *First*, HHS provides no meaningful basis to disregard its recent statement in litigation, specifically concerning the topic of pregnancy counseling in government-funded programs, that "*in general*, counseling [including information] and referrals are distinct." *See* Providers' SJ Br. 25. HHS argues it did not intend to bind the agency's position "in any statute, let alone the Coats-Snowe and Weldon Amendments." HHS Reply Br. 16. But whether or not the agency meant to

bind itself, it provided its assessment of what these words mean "in general" (and indeed in a similar context), and it has no explanation why the same words do not have the same meaning under the statutes at issue here. *Second*, HHS also argues that whether or not the Rule's definition of "referral" / "refer for" comports with medical ethics is of no consequence because the meaning of these terms is a "legal" question. *Id.* at 15. But surely Congress did not intend to import into federal law a counterintuitive definition of "referral" / "refer for" that also allows for individuals to violate medical ethics to the detriment of patients.

4. "Health care entity". For the purpose of the Coats-Snowe Amendment, HHS provides no response to Plaintiffs' argument, *see* Providers' SJ Br. 28, that neither a "pharmacy," a "medical laboratory" nor "an entity engaging in biomedical or behavioral research project" can be considered a "participant in a program of training in the health professions." Thus, even under HHS's own argument pressed in its prior briefing that Coats-Snowe was intended to extend to any entity that falls under the "catch-all phrase[]" "participant[s] in a program of training in the health professions," HHS SJ Br. 38, the Rule's definition of "health care entity" is still contrary to the Coats-Snowe Amendment. Defendants attempt to dismiss the fact that the title of Coats-Snowe focuses on "physicians"; that Coats-Snowe was enacted to address requirements to ob-gyn residency training of physicians; and that the legislative history is replete with statements from the statute's sponsors that make clear they were focused on the training of physicians in ob-gyn residency program, on the basis that each should be given little weight. *See* HHS Reply Br. 14; Def.-Int. Reply Br. 9. But when each of these points are taken together, it is overwhelmingly clear that Congress defined "health care entity" in a limited manner. The Rule's drastic expansion of the term to sweep in entities that are not in any way related to the training of physicians to perform abortions contravenes Congress's intent.

HHS similarly does not respond to Plaintiffs' argument that the Rule defines "health care entity" for the purpose of Weldon in a manner that is inconsistent with even HHS's own reading of Weldon by including entities such as "plan sponsor[s]" and "third-party administrator[s]." *See* Providers' SJ Br. 28. While Defendants-Intervenors attempt to argue that "plan sponsors" are "easily encompassed within 'any other kind of health care facility, organization, or plan,'" Def.-Int. Reply Br. 9, they do not contend with Plaintiffs' argument that plan sponsors, which reach employers with no connection to health care other than the provision of employee benefits, are unlike "other kind[s] of health care facilit[ies], organization[s], or plan[s]" that are engaged in the provision of health care. *See* Providers' SJ Br. 28. The Rule's definitions go far beyond the plain meaning of the statutes and Congressional intent, rendering the Rule contrary to law.

C. The Rule Is Contrary to Other Federal Statutes and Law

As Plaintiffs have explained, *see* Providers' PI Br. 31–38; Providers' SJ Br. 28–40, the Rule is also contrary to other federal statutes and law, including EMTALA, 42 U.S.C. § 1395dd; Section 1554 of the Patient Protection and Affordable Care Act (ACA), 42 U.S.C. § 18114; congressional mandates of the Title X program, *see* Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, Pub. L. No. 115-245, 132 Stat. 2981, 3070–71 (2019), and the Establishment Clause of the U.S. Constitution. Defendants' arguments to the contrary are unavailing.

1. EMTALA. Defendants advance several arguments in response to Plaintiffs' claim that the Rule conflicts with EMTALA, nearly all of which rest on a fundamental misrepresentation of the Rule's terms and the restrictions it imposes on health care providers.

First, HHS argues that the Rule cannot conflict with EMTALA because "Plaintiffs and their health departments" are able to "assess[] when or if a particular health care entity will object to providing any particular service," and can "make non-discriminatory staffing decisions and . . .

develop other methods precisely to ensure that patients receive needed care." HHS Reply Br. 17; *see also* Def.-Int. Reply Br. 10 (advancing similar argument). As an initial matter, the Rule bars employers from asking applicants or employees whether they are willing to perform the essential functions of the job more than "once per calendar year," unless Plaintiffs can demonstrate a "persuasive justification." 84 Fed. Reg. at 23,263 (§ 88.2(5)). And as Plaintiffs have explained, *see, e.g.*, Providers' SJ Br. 18 n.7, 45 n.30, which Defendants do not dispute, the Rule's failure to define what qualifies as a "persuasive justification" will leave health care providers reluctant to asking employees about their objections beyond once "per calendar year," since HHS is allowed to determine after the fact that this was unlawful discrimination and impose penalties under the Rule. Thus, not only does the Rule unjustifiably put the burden on health care providers to discover whether employees have objections that may interfere with patient care, the Rule severely constrains their ability to do so.

Moreover, as Plaintiffs explained in prior briefing, *see, e.g.*, Providers' SJ Br. 17–18, 30–31, and again above, *supra* Parts II.A.–B., the Rule's definition of "discriminate" prevents hospitals from making "staffing decisions" to ensure patient care. Employers cannot avoid liability by offering reasonable accommodations—such as reassigning an employee to a position with responsibilities they are willing to perform—unless the employee "voluntarily accepts" them. *See* 84 Fed. Reg. at 23,263 (§ 88.2(4)). And even if the employee did voluntarily accept the reassignment, that would not prevent the agency from finding a violation because, as the Rule expressly states "it is not an acceptable practice under [the refusal statutes] . . . to deem persons with religious or moral objections to . . . abortion[] to be disqualified for certain job positions on that basis," e.g., a hospital "could not deem . . . a nurse with a religious objection to performing abortions to be ineligible to practice obstetrics and gynecology." 84 Fed. Reg. at 23,191.

Accordingly, even where an employer is aware of an employee with objections to performing emergency abortion services, the Rule also prevents them from making any staffing decisions on that basis. The Rule thus directly conflicts with EMTALA's *statutory* mandate.

Second, and for much the same reasons, Defendants-Intervenors' attempts to distinguish *Shelton* also fail, as they likewise rest on the flawed argument that the Rule does not "necessarily" forbid an employer from terminating or reassigning an employee who refuses an accommodation. Def.-Int. Reply Br. 10. Plaintiffs have already explained above, *see supra* Part II.A., that this new reading of the Rule is not supported by the Rule's actual text. In addition, Defendants-Intervenors ignore that the Third Circuit in *Shelton* held that Title VII permitted a hospital to terminate a nurse who refused to assist in an abortion necessary to "treat an[] emergency patient [experiencing placenta previa] . . . who was standing in a pool of blood," 223 F.3d at 223, and who had refused a transfer from the labor and delivery department to the neonatal intensive care unit (NICU). In contrast, the Rule would forbid the hospital's conduct as an exclusion from a "field of practice." *See* 84 Fed. Reg. at 23,263 (§ 88.2(6)). By prohibiting employers from making staffing arrangements based on the emergency services employees are willing to provide, the Rule does not account for the dangers it presents to patients experiencing life-threatening emergencies, as *Shelton* all too starkly illustrates.[16]

Third, HHS next suggests that Plaintiffs' "real concern" is that "Plaintiffs may incur additional costs" because the Rule requires that employers "engage in some level of 'double staff[ing]' in order to avoid discriminating against an objecting employee." HHS Reply Br. 18

[16] Defendants-Intervenors harp on the fact that "the nurse in [*Shelton*] refused to engage in any discussions with her employer regarding acceptable accommodations, even though the hospital offered a specific accommodation and invited her to 'identify other available nursing positions.'" Def.-Int. Reply Br. 10 (quoting *Shelton*, 223 F.3d at 223). But the Rule requires a health care employer to provide absolute accommodation to employees, regardless of whether any, or how many, "discussions" occurred.

(quoting Providers' SJ Br. 31, 32). But Plaintiffs have already made clear, *see* Providers' SJ Br. 32, even if double staffing were financially feasible for emergency departments that "operate on tight budgets," which it is not, patients with life-threatening injuries and illnesses often cannot wait for another physician to treat them if their current provider refuses to provide care. *See* AR 000147981–85 (Comment, Am. Coll. of Emergency Physicians, ECF No. 180-40 (Ex. 106)). HHS presents an imaginary world where every emergency physician has a shadowing backup physician at all times, ready to provide emergency care at a moment's notice in the event that the treating physician had a religious or moral objection to the required procedure. This cannot be.[17]

Finally, HHS raise for the first time the unmeritorious argument that Plaintiffs do not have standing to argue "that some religiously affiliated hospitals may decide to turn away patients in some circumstances that would run afoul of EMTALA." HHS Reply Br. 18. As an initial matter, Plaintiffs have demonstrated that the Rule would allow for refusals of care that conflict with the mandates of EMTALA not only in religious hospitals, but in any hospital subject to the Rule, including those operated by State Plaintiffs.[18] *See* Providers' SJ Br. 28–34. Moreover, once a litigant has established standing to challenge the lawfulness of agency action on at least one

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[17] Plaintiffs have pointed to evidence in the record of Catholic hospitals that have in the past considered certain treatment for ectopic pregnancies to be an impermissible abortion, *see* Providers' SJ Br. 34 & n.18, yet Defendants-Intervenors ask this Court to take judicial notice of Dr. Stevens' reading of various "statements of faith," Def.-Int. Reply Br. 11 & n.6. Whether "religious groups permit removal of ectopic pregnancies, particularly where necessary to save the life or health of the mother," Stevens Decl. ¶ 22, ECF No. 151 (1:19-cv-4676), or "oppose[] the provision of care" in the case of a miscarriage, *id*. ¶ 24, cannot "be accurately and readily determined from sources whose accuracy cannot reasonably be questioned." Fed. R. Evid. 201(b). *Compare Magnoni v. Smith & Laquercia*, 483 F. App'x 613, 616 (2d Cir. 2012) (cited by Defendants-Intervenors) (taking judicial notice that "Quickie" is a brand of wheelchair). Moreover, statements in Dr. Stevens' declaration cannot supplant the administrative record.

[18] Provider Plaintiffs have also explained that "while abortion is a very safe medical procedure, some of PPNNE's abortion patients who experience complications need to seek care at hospitals," and even patients who "are not experiencing a complication" may nevertheless be "concerned about signs or symptoms and … seek care at hospitals or with other providers." Gallagher Decl. ¶ 51. "In addition, a patient who chooses to continue her pregnancy to term may either spontaneously abort (this is commonly called miscarriage), or develop a medical complication so serious that it is medically advisable to terminate the pregnancy," and these patients too may seek care at a hospital. *Id.* at ¶ 52.

ground, that litigant is entitled to raise other inadequacies stemming from the same action. *See DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 353 n.5 (2006) (holding that once a litigant has standing to request invalidation of a particular agency action, it may do so by identifying all grounds on which the agency may have "failed to comply with its statutory mandate." (quoting *Sierra Club v. Adams*, 578 F.2d 389, 392 (D.C. Cir. 1978))).

2. Section 1554 of the ACA. As Plaintiffs explained in prior briefing, Section 1554 of the ACA, 42 U.S.C. § 18114, barred HHS from promulgating the Refusal Rule. *See* Providers' PI Br. 37–38; States' PI Br. 30–32; Providers' SJ Br. 36–40. HHS has now abandoned many of its earlier counter-arguments, including that the Rule is outside the scope of Section 1554's prohibitions because the Rule "denies nothing," HHS SJ Br. 43, and does not "impede . . . anything" *id.* at 44 n.5. Nor does HHS continue to press that Section 1554 is too "open-ended" to be enforced. *Id.* at 45. Instead HHS falls back on the argument that Section 1554 cannot be read to apply to the Rule because doing so would "render meaningless (if not completely abrogate)" the refusal statutes. HHS Reply Br. 21. This assumes the Rule is not only a faithful interpretation but the *only* available interpretation of the statutes that could "give effect to the [refusal] statutes" without "violat[ing] Section 1554." *Id.* at 21–22. Both assumptions are incorrect.

As set forth above, *supra* Parts II.A.–B., the Rule extends refusal rights beyond those provided by the statutes and prevents employers from ensuring alternative means of providing services and information. Providers' SJ Br. 37. The barriers and restrictions imposed on providers by the Rule are therefore different in kind than any that already exist; and they plainly violate Section 1554. HHS also mischaracterizes Plaintiffs' interpretation of Section 1554 as preventing essentially *any* regulation of health care. HHS Reply Br. 22. Not so—Section 1554 itself contains internal limiting principles, *e.g.*, regulations may not create "*unreasonable* barriers" or "impede[]

timely" (not immediate) access (emphasis added). Ministerial regulations consistent with the scope of existing statutory refusal rights, or typical regulation of Medicare and Medicaid, would therefore not necessarily implicate Section 1554; but that is not what HHS has done here.

Finally, HHS attempts to rely on the ACA's provision that specifically references refusal, Section 1303(c)(2), *see* HHS Reply Br. 21–22, but this provision actually shows that Section 1554 and the refusal statutes can and have coexisted. At the time of drafting the ACA, Congress was well-aware of the refusal statutes, and any tension between the refusal statutes and patient access to care was balanced by, for example, Title VII and EMTALA. But Section 1554 placed an outer limit on any discretion HHS would otherwise have to upset this balance via regulations that create unreasonable barriers to care *inter alia* (not that HHS has such authority in the first instance, *see supra* Part I.A.). The Rule blows past this outer limit in violation of Section 1554.

3. Title X. Defendants appear to advance the erroneous argument that the Rule cannot conflict with Title X because Plaintiffs have not pointed to a statute with which Plaintiffs allege the Rule conflicts. HHS Reply Br. at 19–20. However, as Plaintiffs have explained from the outset, the Rule conflicts with the nondirective counseling mandate, which has been a statutory condition of every annual Title X appropriation since 1996. Providers' SJ Br. at 35–36. It is well-established that Congress can legislate through an appropriation statute. *Robertson v. Seattle Audubon Soc'y*, 503 U.S. 429, 440 (1992). Defendants recycle their previous arguments which hinge on a fundamental misunderstanding of what it means for pregnancy counseling to be nondirective—which, as Plaintiffs have explained, requires that a pregnant patient have access to information about all of their options so that a patient is not directed to one option over another. And yet, as Defendants admit, the Rule requires Title X providers to keep on staff individuals who refuse to comply with the nondirective counseling mandate.

4. Establishment Clause. Defendants cannot dispute that, as the Supreme Court has repeatedly affirmed, "[a]t some point, accommodation [of religious beliefs] may devolve into 'an unlawful fostering of religion.'" *Corp. of Presiding Bishop of the Church of Jesus Christ of Latter-day Saints v. Amos*, 483 U.S. 327, 334–35 (1987) (quoting *Hobbie v. Unemployment Appeals Comm'n of Fla.*, 480 U.S. 136, 145 (1987)); *see also, e.g., Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 732 (2014); *Cutter v. Wilkinson*, 544 U.S. 709, 720 (2005); *Bd. of Educ. of Kiryas Joel Vill. Sch. Dist. v. Grumet*, 512 U.S. 687, 706 (1994). Nor can Defendants dispute that in the employment context the Supreme Court has drawn that line clearly: A law which "imposes on employers and employees an absolute duty to conform their business practices to the particular religious practices of the employee," violates the Establishment Clause. *Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 708–9 (1985). Here, the plain language of the Rule crosses that line—it imposes on Plaintiffs an absolute duty to accommodate an employee's religiously motivated refusal to perform even essential job functions, with "no exception under [the Rule] for special circumstances," no "special consideration" for whether an employer's workforce can actually accommodate such refusals, and "no exception [for] when honoring the [refusal] would cause the employer substantial economic burdens or when the employer's compliance would require the imposition of significant burdens on other employees." *Id.* at 709–10. As such, the Rule violates the Establishment Clause.[19]

Contrary to Defendants' contentions, *Thornton* is directly relevant to the question of whether a rule requiring religious accommodations in the workplace violates the Establishment Clause. HHS Reply Br. 43–44; Def.-Int. Reply Br. 22–23. HHS's claim that the Supreme Court in *Thornton* was not concerned with the "absoluteness" of the challenged law, but solely with the fact

[19] Defendants' argument that the Rule permits employers to refuse to accommodate religious objections, *see e.g.*, HHS Reply Br. 42; Def.-Int. Reply Br. 22–24, are without merit. *See supra* Part II.A.

that it "offered a benefit only to the religiously inclined," HHS Reply Br. 43, is simply not credible. *See Thornton*, 472 U.S. at 709–10. The essential holding of *Thornton* is that a law that required *some* accommodation of employees' observance of Sabbath would not necessarily violate the Establishment Clause; but a law imposing an "absolute and unqualified" duty on an employer to do so does. *Id.* at 709.[20]

Defendants' remaining arguments are unavailing. *See generally* Providers' SJ. Br. 41–44. *First*, HHS repeats its claim that the Rule cannot violate the Establishment Clause because the federal refusal statutes do not. HHS Reply Br. 42–43. This is a non sequitur. As explained *supra* Part II.A., Plaintiffs do not challenge the underlying refusal statutes because the underlying refusal statutes do not impose on employers an absolute obligation to accommodate their employees' religious beliefs regardless of the burden it imposes on employers, co-workers, and patients.[21]

Second, HHS repeats its contention that the Rule's application to moral convictions that mirror religious beliefs immunizes the Rule from an Establishment Clause challenge. HHS Reply Br. 43–45. However, the Rule's text and record demonstrate that it is primarily intended to advance

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[20] HHS cites, HHS Reply Br. 43, *Texas Monthly, Inc. v. Bullock*, 489 U.S. 1 (1989) but that case is inapposite, as it did not concern a law commanding workplace accommodation of religious beliefs. It seems HHS is confusing *Texas Monthly*—which did not deal with property tax exemptions and invalidated, rather than upheld, the challenged law, *id.*—with *Walz v. Tax Commission of NYC*, 397 U.S. 664 (1970). Even so, *Walz* upheld a property tax exemption that applied to churches (as well as a variety of charitable and educational institutions) as it "simply abstains from demanding that the church support the state." 397 U.S. at 666–67, 675. The Rule takes the opposite approach, and demands that secular employers conform to the religious practices of their employees.

[21] As HHS concedes, *see* HHS Reply Br. 42. no court has considered whether the Church Amendment creates an absolute duty to accommodate an employee's religiously motivated refusals, let alone construed it to create such a requirement. *Chrisman v. Sisters of St. Joseph of Peace*, 506 F.2d 308 (9th Cir. 1974), is completely inapplicable. The only claim in *Chrisman* related to subsection (b) of the Church Amendments, which is not at issue here. *Id.* at 310–11. Subsection (b) prevents the receipt of certain federal funds from being used to require *entities* to perform abortions or sterilizations; it is not an employment provision, and does not describe how the statutes apply where a health care entity *does* provide care to which an *employee* objects. *Id.* at 311–12. Thus, even if HHS is correct that the Rule's accommodation requirements match the statutes', *Chrisman* does not, nor could it, define what constitutes an acceptable employment accommodation for purposes of the Establishment Clause.

and privilege specific religious beliefs, Providers' SJ Br. 43–44—something that Defendants-Intervenors, unsurprisingly, do not question, Def.-Int. Reply Br. 23. Indeed, HHS cannot refute the evidence that the *Rule* was promulgated in order to privilege and advance religious beliefs. The Rule plainly "single[s] out a particular class of such persons for favorable treatment," *Hobbie*, 480 U.S. at 145 n.11, based on their religious beliefs—those with religious opposition to providing certain health care services and information—in a manner the Supreme Court has already held impermissible under the Establishment Clause. The moral beliefs likewise privileged by the Rule are not meaningfully distinguishable from such religious beliefs. *See Welsh v. United States*, 398 U.S. 333, 340 (1970);[22] *see also* Providers' SJ Br. 43–44 & n.29.

Third, Defendants likewise repeat their argument that the Establishment Clause does not "flatly prohibit accommodations that may burden third parties." HHS Reply Br. 45–46; Def.-Int. Reply Br. 24–25. But as set forth above, the Supreme Court *does* flatly prohibit imposing on employers an absolute duty to accommodate an employee's religious beliefs. *See Thornton*, 472 U.S. 708–710. Whether a different accommodation requirement might not violate the Establishment Clause, notwithstanding the burdens it imposes on third parties, is irrelevant.[23]

Finally, Plaintiffs have already established that their Establishment Clause claim is ripe. *See* Providers' SJ Br. 45–48. If the Rule takes effect, Plaintiffs would have to "to adjust [their]

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[22] As such, this case is a far cry from the situation in *Hobbie*—a case that primarily arose under the Free Exercise clause, not the Establishment Clause—where the Supreme Court held that religious observers should not be excluded from receiving unemployment benefits that were generally available. 480 U.S. at 139–40, 145 n.11. Here, by contrast, the Rule affords employees with particular religious views rights and privileges that are not available to other employees, and "places an unacceptable burden on employers and co-workers." *Id.* at 145 n.11 (citing *Thornton*, 472 U.S. at 710).

[23] Defendants-Intervenors, again, attempt to rely on *Amos*, 483 U.S. 327, (which Plaintiffs have already explained is distinguishable, *see* Providers' SJ Br. 42), and continue to misrepresent Plaintiffs' position as stating that "religious accommodations become unconstitutional *whenever* they impose burdens on third parties." Def.-Int. Reply Br. 25 (emphasis added). The Supreme Court in *Thornton*, 472 U.S. at 710, identified the point at which an accommodation crosses the line, and the Rule has plainly exceeded it. *See also Amos*, 483 U.S. at 337 n.15 (distinguishing *Amos* from *Thornton*).

conduct immediately" to conform to the Rule's unconstitutional requirements, *Nat'l Park Hosp. Ass'n v. Dep't of Interior*, 538 U.S. 803, 808 (2003) (citing *Lujan v. Nat'l Wildlife Fed'n*, 497 U.S. 871, 891 (1990)), by fundamentally altering their hiring and employment policies, *see* Providers' SJ Br. 45–46. Whether the Rule violates the Establishment Clause thus presents a concrete legal dispute that is fit for adjudication without any need to wait for a future enforcement action. *Citizens United v. Schneiderman*, 882 F.3d 374, 388 (2d Cir. 2018). Indeed, the Rule uses the threat of enforcement proceedings *in the future* for the express purpose of forcing Plaintiffs to make such significant—and unconstitutional—changes to their policies and practices *now*. *See* Providers' S J Br. 46–48. Thus, Defendants utterly fail to refute the hardship Plaintiffs will suffer if judicial review is deferred and Plaintiffs are instead required to choose between implementing an unconstitutional policy or risking enforcement action before their claims can be adjudicated. *See Sharkey v. Quarantillo*, 541 F.3d 75, 90 (2d Cir. 2008).

CONCLUSION

For the reasons set forth above, and in prior briefing, Plaintiffs respectfully request that the Court vacate and set aside the Final Rule, or in the alternative, enter a preliminary injunction pending resolution of Plaintiffs' claims on the merits.

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Respectfully submitted,

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