Nos. 23-726 & 23-727

In the Supreme Court of the United States

MIKE MOYLE, SPEAKER OF THE IDAHO HOUSE OF REPRESENTATIVES, ET AL.,

Petitioners,

v.

UNITED STATES OF AMERICA,

Respondent.

STATE OF IDAHO,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF *AMICUS CURIAE* OF THE CHRISTIAN MEDICAL & DENTAL ASSOCIATIONS IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Whether EMTALA preempts state laws that protect human life and prohibit abortions, like Idaho's Defense of Life Act.

TABLE OF CONTENTS

Page

QUESTION PRESENTED i

TABLE OF AUTHORITIES iii

INTEREST OF THE *AMICUS* 1

INTRODUCTION AND SUMMARY OF ARGUMENT 2

ARGUMENT 3

I. The EMTALA guidance is unlawful because it fails to account for RFRA. 3

A. RFRA constrains federal agency action. 4

B. HHS is well aware that healthcare regulations will impact religious liberty. 6

i. The contraceptive mandate 7

ii. The transgender mandate 10

C. The EMTALA guidance is unlawful because it completely ignores RFRA. 17

II. The EMTALA guidance violates the major questions doctrine. 23

CONCLUSION 28

TABLE OF AUTHORITIES

Page(s)

Cases

Alabama Ass'n of Realtors v. *HHS*,
141 S. Ct. 2485 (2021) 24

Biden v. *Nebraska*,
143 S. Ct. 2355 (2023) 24, 25, 26, 27

Bostock v. *Clayton County*,
590 U.S. 644 (2020) 4

Burwell v. *Hobby Lobby Stores, Inc.*,
573 U.S. 682 (2014) 4, 7, 19, 21

California Democratic Party v. *Jones*,
530 U.S. 567 (2000) 20

Church of Lukumi Babalu Aye, Inc. v.
City of Hialeah,
508 U.S. 520 (1993) 20, 21

City of Boerne v. *Flores*,
521 U.S. 507 (1997) 19

Dobbs v. *Jackson Women's Health Org.*,
597 U.S. 215 (2022) 20, 27

FDA v. *Brown & Williamson Tobacco
Corp.*,
529 U.S. 120 (2000) 24-25, 26

Franciscan All., Inc. v. *Azar*,
414 F. Supp. 3d 928 (N.D. Tex. 2019)..... 15

Franciscan All., Inc. v. *Becerra*,
47 F.4th 368 (5th Cir. 2022) 2, 15-16

Franciscan All., Inc. v. *Becerra*,
553 F. Supp. 3d 361 (N.D. Tex. 2021)..... 15

Franciscan All., Inc. v. *Becerra*,
843 Fed. Appx. 662 (5th Cir. 2021)..... 15

Franciscan All., Inc. v. *Burwell*,
227 F. Supp. 3d 660 (N.D. Tex. 2016)..... 14, 19

Gonzales v. *O Centro Espírita
Beneficente União do Vegetal*,
546 U.S. 418 (2006) 21

Gonzales v. *Oregon*,
546 U.S. 243 (2006) 24, 27

Holt v. *Hobbs*,
574 U.S. 352 (2015) 4, 21, 22

*Little Sisters of the Poor Saints Peter &
Paul Home* v. *Pennsylvania*,
140 S. Ct. 2367 (2020) 5, 6, 7, 10, 11, 17, 20

McCullen v. *Coakley*,
573 U.S. 464 (2014) 22

NFIB v. *OSHA*,
595 U.S. 109 (2022) 23-24, 27

Priests for Life v. *HHS*,
808 F.3d 1 (D.C. Cir. 2015) 23

Religious Sisters of Mercy v. *Azar*,
513 F. Supp. 3d 1113 (D.N.D. 2021)..... 16, 19

Roman Catholic Diocese of Brooklyn v. *Cuomo*,
592 U.S. 14 (2020) 26

Sharpe Holdings, Inc. v. *U.S. Dep't of Health & Hum. Servs.*,
801 F.3d 927 (8th Cir. 2015) 19

Sherbert v. *Verner*,
374 U.S. 398 (1963) 20-21

Texas v. *Becerra*,
89 F.4th 529 (5th Cir. 2024) 1-2, 18

Utility Air Regul. Grp. v. *EPA*,
573 U.S. 302 (2014) 25

West Virginia v. *EPA*,
597 U.S. 697 (2022) 23, 24, 26, 27, 28

Zubik v. *Burwell*,
578 U.S. 403 (2016) 7, 9

Statutes

20 U.S.C. 1681 12

42 U.S.C. 238n 21

42 U.S.C. 300a-7 21

42 U.S.C. 300gg-13 7

42 U.S.C. 1395dd 20

42 U.S.C. 2000bb-1 ..... 4, 5, 19

42 U.S.C. 2000bb-2 5

42 U.S.C. 2000bb-3 ..... 4, 5

42 U.S.C. 18023 22

42 U.S.C. 18113 22

42 U.S.C. 18116 ..... 10, 12

2023 Consolidated Appropriations Act,
Pub. L. No. 117-328 22

Regulations

76 Fed. Reg. 46,621 (Aug. 3, 2011) 7, 8

77 Fed. Reg. 8725 (Feb. 15, 2012) 8

78 Fed. Reg. 39,870 (July 2, 2013) 9

80 Fed. Reg. 54,172 (Sept. 8, 2015) 10, 11

81 Fed. Reg. 31,376 (May 18, 2016) 11, 12, 13

82 Fed. Reg. 47,792 (Oct. 13, 2017) 10

83 Fed. Reg. 57,536 (Nov. 15, 2018) 10

85 Fed. Reg. 37,160 (June 19, 2020) 15

87 Fed. Reg. 47,824 (Aug. 4, 2022) 16

Other Authorities

Catholic Health Ass'n, Comment Letter on Nondiscrimination in Health Programs and Activities (Nov. 9, 2015) 11

Catholic Med. Ass'n, Comment on Preventive Services Coverage (Sept. 17, 2010) 8

Christian Med. & Dental Ass'n, Comment Letter on Nondiscrimination in Health Programs and Activities (Oct. 1, 2022) 16

Christian Med. Ass'n, Comment on Interim Final Rule (Sept. 29, 2011) 8

Church All., Comment Letter on Nondiscrimination in Health Programs and Activities (Nov. 9, 2015) 11

CMDA Ethics Statement: Transgender Identification (adopted Oct. 30, 2021) 14

Council for Christian Colls. & Univs., Comment Letter on Nondiscrimination in Health Programs and Activities (Nov. 9, 2015) 11

Council for Christian Colls. & Univs., Comment on the Interim Final Rules (Sept. 30, 2011) 8

Family Rsch. Council, Comments on Interim Final Rule (Sept. 30, 2011) 8

HHS, *Notification of Interpretation and Enforcement of Section 1557 of the Affordable Care Act and Title IX of the Education Amendments of 1972* (May 10, 2021) 15

Douglas Laycock & Oliver S. Thomas, *Interpreting the Religious Freedom Restoration Act*, 73 Tex. L. Rev. 209 (1994) 5

Michael W. McConnell, *The Ninth Amendment in Light of Text and History*, 2009-2010 Cato Sup. Ct. Rev. 13 25-26

Muslim Religious Freedom All., Comment Letter on Nondiscrimination in Health Programs and Activities (Sept. 22, 2022) 16

Michael Stokes Paulsen, *A RFRA Runs Through It: Religious Freedom and the U.S. Code*, 56 Mont. L. Rev. 249 (1995) 4

Mark L. Rienzi, *The Constitutional Right Not to Kill*, 62 Emory L. J. 121 (2012) 22

Mark L. Rienzi, *Fool Me Twice:* Zubik v. Burwell *and the Perils of Judicial Faith in Government Claims*, 2015-2016 Cato Sup. Ct. Rev. 123 9

U.S. Conf. of Catholic Bishops, Comment Letter on Nondiscrimination in Health Programs and Activities (Sept. 7, 2022) 16-17

U.S. Conf. of Catholic Bishops, Comment on Interim Final Rules (Aug. 31, 2011) 8

U.S. Conf. of Catholic Bishops, Comment on Preventive Services Coverage (Sept. 17, 2010) 8

U.S. Conf. of Catholic Bishops, Comment Letter on Nondiscrimination in Health Programs and Activities (Nov. 6, 2015) 11

U.S. Dep't of Labor, *FAQs About Affordable Care Act Implementation Part 36* (Jan. 9, 2017) 10

INTEREST OF THE *AMICUS*[1]

The Christian Medical & Dental Associations (CMDA) is a non-profit, non-partisan 501(c)(3) organization that provides resources, programs, education, and services with a motto of "changing hearts in healthcare," and for the purpose of providing a public voice for its current membership of more than 12,000 Christian healthcare professionals. Founded in 1931, CMDA is committed to bringing hope and healing to the world by educating, encouraging, and equipping healthcare professionals to serve with excellence and compassion, care for all people, and advance Biblical principles of healthcare within the church and throughout the world. To this end, CMDA promotes positions and addresses policies on healthcare issues and distributes educational and inspirational resources through publications, conferences, and multimedia programs.

CMDA has a longstanding interest in advocating for the dignity of the medical profession and the protection of all human life. That interest is rooted in its fundamental belief that all humans are made in the image of God. These religious beliefs compelled CMDA to file suit alongside the state of Texas and the American Association of Pro-Life Obstetricians and Gynecologists to challenge HHS's sweeping claim that the Emergency Medical Treatment and Labor Act (EMTALA) permits it to mandate abortions in emergency departments across the country. See *Texas* v. *Becerra*,

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[1] No counsel for a party authored this brief in whole or in part and no person other than *Amicus*, its members, or its counsel made a monetary contribution intended to fund the preparation or submission of this brief.

89 F.4th 529 (5th Cir. 2024). CMDA also spent more than six years litigating against HHS's attempts to force religious healthcare professionals to provide abortion, sterilization, and gender transitions under the Affordable Care Act. See *Franciscan All., Inc.* v. *Becerra*, 47 F.4th 368 (5th Cir. 2022).

CMDA submits this brief to urge the Court to make it clear that agencies, particularly HHS as a repeat offender, may not ignore RFRA or the major questions doctrine to coerce those with religious objections to either abandon their religious beliefs or exit the public square.

INTRODUCTION AND SUMMARY OF ARGUMENT

Once again, HHS has plucked the proverbial elephant from a mousehole. This time, the agency has discovered long-hidden regulatory authority within EMTALA's capacious penumbra. HHS is using that newly discovered authority to do what Congress has not prescribed, and in fact to do what Congress has *proscribed*—trample the religious freedom rights of healthcare professionals. Petitioners have ably argued why HHS lacks authority to preempt state law with its EMTALA guidance. *Amicus* submits this brief to demonstrate how HHS's EMTALA guidance fails for two additional and independent reasons.

First, HHS completely failed to consider—let alone justify its actions under—the Religious Freedom Restoration Act (RFRA), flouting that statute's plain text. This failure would be egregious enough in the normal course, but this is hardly the normal course. HHS has spent more than a decade embroiled in litigation over

the contraceptive mandate and the transgender mandate, regulations that impose draconian penalties on religious healthcare professionals who serve their communities. In that time, HHS has repeatedly used its regulatory authority to trample the rights of religious objectors. Federal courts—including this Court—have had to repeatedly intervene to ensure the agency follows RFRA. But here, HHS didn't even try, instead dashing off a guidance document just weeks after this Court's *Dobbs* decision in a transparent attempt to protect access to abortion at all costs. The guidance makes no attempt to account for RFRA and is unlawful for that reason alone.

Second, HHS's continued disregard of religious exercise illustrates a deeper problem with its actions over the last thirteen years. Because it regulates on politically sensitive issues in the absence of express authority from Congress—and in ways that will foreseeably infringe religious exercise—HHS's regulations routinely implicate (and ignore) a paradigmatic major question.

HHS's actions here far exceed its authority. This Court should make clear that HHS can no longer employ these all-too-familiar tactics to strip healthcare professionals of their free exercise rights.

ARGUMENT

I. The EMTALA guidance is unlawful because it fails to account for RFRA.

HHS offered an interpretation of EMTALA but ignored an even more consequential federal statute: RFRA. HHS is obligated to consider RFRA when it regulates. Its failure to do so here was especially glaring given the agency's long history of regulating without

proper consideration of RFRA and then seeing its regulations limited, vacated, or enjoined. RFRA's test applies to the EMTALA guidance, and that guidance fails every single one of RFRA's demands.

A. RFRA constrains federal agency action.

Congress enacted RFRA to provide "very broad protection for religious liberty." *Holt* v. *Hobbs*, 574 U.S. 352, 356 (2015). Under RFRA, the federal government may not "substantially burden a person's exercise of religion" unless that burden is the "least restrictive means" of furthering a "compelling governmental interest." 42 U.S.C. 2000bb-1(a)-(b). RFRA's protections must be construed "in favor of a broad protection of religious exercise" to the "maximum extent" possible. *Burwell* v. *Hobby Lobby Stores, Inc.*, 573 U.S. 682, 696 & n.5 (2014) (quoting 42 U.S.C. 2000cc-3(g) and applying RLUIPA's "broad" construction rule to RFRA).

RFRA "applies to all Federal law, and the implementation of that law," except where an underlying statute "explicitly excludes such application." 42 U.S.C. 2000bb-3(a)-(b). It thus "operates as a kind of super statute, displacing the normal operation of other federal laws." *Bostock* v. *Clayton County*, 590 U.S. 644, 682 (2020); see also Michael Stokes Paulsen, *A RFRA Runs Through It: Religious Freedom and the U.S. Code*, 56 Mont. L. Rev. 249, 253-254 (1995) (RFRA "cut[s] across all other federal statutes (now and future, unless specifically exempted) and modif[ies] their reach").

The text of RFRA plainly includes federal agency action within its sweep. That follows from the applicability provision, which specifies that RFRA "applies to all Federal law, and the *implementation* of that law,

whether statutory or otherwise." 42 U.S.C. 2000bb-3(a) (emphases added). It follows too from the core duty that RFRA imposes on the "government"—which is broadly defined to include any "branch, department, agency, instrumentality, and official * * * of the United States"—not to "substantially burden a person's exercise of religion" absent a showing of compelling governmental interest and least restrictive means. 42 U.S.C. 2000bb-1(a)-(b), 2000bb-2(1). In sum, RFRA operates as "both a rule of interpretation" and "an exercise of general legislative supervision over federal agencies." Douglas Laycock & Oliver S. Thomas, *Interpreting the Religious Freedom Restoration Act*, 73 Tex. L. Rev. 209, 211 (1994).

This Court has expressly rejected the suggestion that agencies must wait to consider RFRA until a court finds a RFRA violation. In *Little Sisters of the Poor Saints Peter & Paul Home* v. *Pennsylvania*, the Court rebuffed the argument that three agencies, including HHS, "could not even consider RFRA as they formulated the religious exemption from the contraceptive mandate." 140 S. Ct. 2367, 2382-2383 & n.11 (2020); see also *id.* at 2407 & n.17 (Ginsburg, J., dissenting) (disclaiming view that agencies can "cure" RFRA violations "only after a court has found a RFRA violation"). Given "the potential for conflict between the contraceptive mandate and RFRA," as well as this Court's past decisions (which "all but instructed the [agencies] to consider RFRA going forward"), *Little Sisters* held that it was fully "appropriate for the [agencies] to consider RFRA." *Id.* at 2383; see also *id.* at 2396 (Alito, J., concurring) ("I would hold not only that it was appropriate for the Departments to con-

sider RFRA, but also that the Departments were required by RFRA to create the religious exemption (or something very close to it)."). "Against this backdrop," it was "unsurprising that RFRA would feature prominently in the [agencies'] discussion" of potential religious exemptions, so that their next attempt "would not pose similar legal problems" as did their prior (failed) attempt. *Id.* at 2383.

Importantly, *Little Sisters* further instructed that if the agencies had *not* "look[ed] to RFRA's requirements or discuss[ed] RFRA at all when formulating their solution," they would "certainly be susceptible to claims" of arbitrary and capricious rulemaking for "failing to consider an important aspect of the problem." *Little Sisters*, 140 S. Ct. at 2384 (citing, e.g., *Motor Vehicle Mfrs. Ass'n of U.S., Inc.* v. *State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983)). In other words, considering RFRA was not merely permissible but *necessary* for reasoned decision making.

B. HHS is well aware that healthcare regulations will impact religious liberty.

This Court's *Little Sisters* decision does more than establish that agencies must consider RFRA in their rulemakings. It also provides a cautionary tale of the intrusive, entangling, and expensive litigation that results when the government fails to meaningfully consider religious freedom in crafting healthcare regulations. HHS has not only forced religious healthcare professionals to choose between their free exercise rights and their call to serve the most vulnerable, but it has also forced them into burdensome civil proceedings to vindicate those rights. And after fighting and

losing such cases for more than a decade, HHS is indisputably aware of the religious liberty implications of its healthcare regulations.

i. The contraceptive mandate

The 2010 Patient Protection and Affordable Care Act (ACA) requires covered employers to offer health coverage that includes "preventive care and screenings" for women. 42 U.S.C. 300gg-13(a)(4). But Congress did not define "preventive care," instead delegating the definition to various administrative agencies, including HHS. See *ibid.* In August 2011, HHS adopted interim final rules defining "preventive care" to cover all FDA-approved female contraceptives, including some that many religious groups object to as abortifacients. 76 Fed. Reg. 46,621 (Aug. 3, 2011). That rule became known as the "contraceptive mandate."

This Court is well aware of the decade (and counting) of RFRA litigation that followed. See *Little Sisters*, 140 S. Ct. at 2373-2379 (summarizing procedural history); see also *Zubik* v. *Burwell*, 578 U.S. 403 (2016); *Hobby Lobby*, 573 U.S. 682. It is also familiar with the "legal odyssey" of the Little Sisters of the Poor, which continues in the lower courts to this day. *Little Sisters*, 140 S. Ct. at 2396 (Alito, J., concurring); see also Brief for Little Sisters of the Poor as Amici Curiae Supporting Petitioners at 11-16, *Loper Bright Enterprises* v. *Raimondo*, No. 22-451 (July 24, 2023), 2023 WL 4830961.

What particularly matters here is that HHS was put on notice—over and over again—of the conflict between its contraceptive mandate and religious freedom. By the time it issued the first set of interim final

rules in August 2011, HHS had already received comments from religious employers expressing concern that the rules would "impinge upon their religious freedom" if it required them to "cover contraceptive services that their faith deems contrary to [their] religious tenets." See, *e.g.*, 76 Fed. Reg. at 46,623.[2]

Then, when HHS adopted a cramped religious exemption, see 76 Fed. Reg. at 46,623—with the predictable result that many religious organizations did not qualify—religious employers submitted hundreds more public comments objecting to the inadequacy of the exemption and urging HHS to follow RFRA instead.[3] But HHS persisted, adopting both the contraceptive mandate itself and the narrow religious exemption with bare assurances that its approach "complie[d] with the Religious Freedom Restoration Act." 77 Fed. Reg. 8725, 8729 (Feb. 15, 2012).

In July 2013, HHS announced a self-styled "accommodation" mechanism that required nonexempt reli-

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[2] See, *e.g.*, U.S. Conf. of Catholic Bishops, Comment on Preventive Services Coverage (Sept. 17, 2010) (representing Catholic bishops in the United States), https://perma.cc/T8PL-S3WK; Catholic Med. Ass'n, Comment on Preventive Services Coverage (Sept. 17, 2010) (largest association of Catholic physicians), https://perma.cc/C3ZG-MCC7.

[3] See, *e.g.*, U.S. Conf. of Catholic Bishops, Comment on Interim Final Rules (Aug. 31, 2011), https://perma.cc/Z8LB-YB6J; Council for Christian Colls. & Univs., Comment on the Interim Final Rules (Sept. 30, 2011) (on behalf of 137 schools), https://perma.cc/N7YJ-66PG; Christian Med. Ass'n, Comment on Interim Final Rule (Sept. 29, 2011), https://perma.cc/7627-EAW6; Family Rsch. Council, Comments on Interim Final Rule (Sept. 30, 2011) (representing hundreds of thousands of American families), https://perma.cc/RNC5-CYJ7.

gious employers to certify their objections to their insurer or third-party plan administrator, which would then trigger the recipient's obligation to provide contraceptive coverage anyway—the exact scheme that many commenters had objected to. 78 Fed. Reg. 39,870, 39,873-39,875 (July 2, 2013). Religious nonprofit organizations across the country—including the Little Sisters of the Poor—filed a spate of lawsuits challenging the "accommodation" under RFRA.

For years thereafter, HHS insisted in litigation that the self-certification mechanism was the only "feasible" option to implement the contraceptive mandate. 78 Fed. Reg. at 39,888. Until it wasn't. Once this Court granted certiorari in several cases challenging the accommodation mechanism, the government eventually conceded that the regulations "could be modified" to better protect religious liberty. *Zubik*, 578 U.S. at 408. See also Mark L. Rienzi, *Fool Me Twice:* Zubik v. Burwell *and the Perils of Judicial Faith in Government Claims*, 2015-2016 Cato Sup. Ct. Rev. 123, 132-142 (describing various concessions). Based on that concession, the Court unanimously vacated the decisions below and directed the parties to attempt to resolve the dispute in a way that would "accommodate[] petitioners' religious exercise." *Zubik*, 578 U.S. at 408.

Post-*Zubik*, HHS and its sister agencies negotiated halfheartedly until after the November 2016 election. Days before the change in presidential administrations, they announced that they were unable to identify a "feasible approach" to modify the accommodation

mechanism.[4] The new administration disagreed, issuing a new rule that finally took RFRA seriously and broadened the religious exemption to cover religious employers like the Little Sisters. See 82 Fed. Reg. 47,792 (Oct. 13, 2017) (interim final rule); see also 83 Fed. Reg. 57,536 (Nov. 15, 2018) (final rule). This Court upheld that rule against state challenge in *Little Sisters*, 140 S. Ct. 2367.

The upshot is this: religious employers have spent over a *decade* battling healthcare regulations that burden their religious beliefs—and are still fending off legal challenges—all because HHS did not consider and properly accommodate those beliefs in the first place. Against that litigation backdrop, it is beyond dispute that HHS *knows* its healthcare regulations implicate religious liberty concerns, particularly when those regulations relate to issues of abortion and contraception.

ii. The transgender mandate

Section 1557 of the ACA prohibits sex-based discrimination by federally funded or administered health programs. 42 U.S.C. 18116(a). In September 2015, HHS announced that its implementing regulations would read this prohibition to include discrimination based on "gender identity," or one's "internal sense of gender." 80 Fed. Reg. 54,172, 54,174 (Sept. 8, 2015). Thus, HHS proposed a "transgender mandate" that would require doctors, nurses, and hospitals to perform gender-transition procedures like hysterectomies, mastectomies, and other treatments designed to

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[4] U.S. Dep't of Labor, *FAQs About Affordable Care Act Implementation Part 36*, 4 (Jan. 9, 2017), https://perma.cc/R3LN-CMSH.

alter a patient's body in response to gender dysphoria—or else be liable for "discrimination." *Id.* at 54,190. The rule would also require healthcare employers to provide insurance coverage for gender transitions to their employees. *Id.* at 54,189-54,190.

Unsurprisingly, HHS's sweeping mandate directly conflicted with the religious beliefs of many healthcare professionals. Equally unsurprisingly, many religious objectors submitted comments alerting HHS that it needed to create a religious exemption or otherwise ensure that the transgender mandate would not substantially burden their religious exercise.[5] In other words, these private parties asked HHS to "overtly consider [their] rights under RFRA." *Little Sisters*, 140 S. Ct. at 2383.

HHS did not. Its final rule left in place the requirement that (even religious) doctors perform gender transition procedures and that (even religious) employers provide insurance coverage for gender transitions. 81 Fed. Reg. 31,376 (May 18, 2016). In doing so,

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[5] See, *e.g.*, Council for Christian Colls. & Univs., Comment Letter on Nondiscrimination in Health Programs and Activities (Nov. 9, 2015) (on behalf of 143 institutions), https://perma.cc/48TQ-45U3; Church All., Comment Letter on Nondiscrimination in Health Programs and Activities (Nov. 9, 2015) (representing Protestant, Jewish, and Catholic churches), https://perma.cc/7GKN-ECT4; Catholic Health Ass'n, Comment Letter on Nondiscrimination in Health Programs and Activities (Nov. 9, 2015) (representing over 2,200 Catholic healthcare systems and organizations), https://perma.cc/Z2J3-4U8D; U.S. Conf. of Catholic Bishops, Comment Letter on Nondiscrimination in Health Programs and Activities (Nov. 6, 2015) (representing Christian Medical Association, National Association of Evangelicals, and others), https://perma.cc/Z3LX-2LSL.

it ignored not one, but two religious exemptions it was required to consider.

First, HHS refused to incorporate Title IX's religious exemption.[6] It was a startling decision, since Congress wrote Section 1557 to expressly incorporate "title IX of the Education Amendments of 1972 (20 U.S.C. 1681 *et seq*.)." 42 U.S.C. 18116(a). This necessarily includes not only Title IX's prohibition against sex discrimination, but also its religious exemption. HHS omitted the latter, reasoning that Title IX's religious exemption "could result in a denial or delay in the provision of health care to individuals and in discouraging individuals from seeking necessary care," and was thus unwarranted. 81 Fed. Reg. at 31,380.

Second, although HHS acknowledged comments from religious healthcare professionals, it breezed past concerns that they "would be substantially burdened [under RFRA] if required to provide or refer for, or purchase insurance covering, particular services such as gender transition services." 81 Fed. Reg. at 31,379. Rather than analyzing its regulation under RFRA, HHS punted the question to future litigation. If an "application" of the rule would violate federal religious protections, HHS promised, "such application would not be required." *Id*. at 31,376. If and when healthcare professionals sought to vindicate their free exercise rights, HHS would "make [those] determinations" as to burden on a case-by-case basis. *Id*. at 31,380. At the

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[6] That broad exemption states that Title IX "shall not apply to an educational institution which is controlled by a religious organization if the application of this subsection would not be consistent with the religious tenets of such organization." 20 U.S.C. 1681(a)(3).

same time, HHS also took the position that it had a compelling interest in ensuring "nondiscriminatory" healthcare access. Had that been true, it would conveniently overcome any such burden. *Ibid.*

HHS's promises forced religious healthcare professionals into a dangerous gamble. Depending on HHS's future views of any particular application of the mandate, those who did not violate their religious beliefs risked losing millions in federal Medicare and Medicaid funding, as well as debarment from government contracting, False Claims Act liability (including treble damages), and other enforcement proceedings brought by the Department of Justice. 81 Fed. Reg. at 31,440, 31,472. As if that were not enough, noncompliant healthcare professionals could also face private lawsuits for damages and attorneys' fees. *Ibid.*

In short, HHS acknowledged that the transgender mandate likely conflicted with the religious beliefs of objectors, but did nothing to alleviate that conflict, claiming that all such disputes could be hashed out in future litigation (with the scale weighted in HHS's favor). This left religious healthcare professionals sitting on a powder keg: if they did not violate their religious beliefs, they would no longer be able to serve patients who depend upon Medicare, Medicaid, or other federal funding, and they would also face other ruinous penalties.

Take CMDA. Its members treat patients (including those with gender dysphoria) for health issues ranging from the common cold to cancer. CMDA's members abide by an Ethics Statement explaining that "Christians affirm the biblical understanding of humankind as having been created male and female," and affirm-

ing the obligation of "Christian healthcare professionals caring for patients struggling with gender identity to do so with sensitivity and compassion."[7] The Ethics Statement precludes "initiat[ing] hormonal and surgical interventions that alter natural sex phenotypes," and states that "supporting a patient's pursuit of gender transitioning procedures is neither loving nor the best means to help that individual who is experiencing gender dysphoria."[8]

By the time HHS issued its final rule, several CMDA members had already received requests for transition-related procedures that they could not provide without violating their religious beliefs. Plus, some CMDA members covered their employees' healthcare costs, and under the transgender mandate, they would now have to cover services related to gender transition. To protect their religious exercise, CMDA, along with Franciscan Alliance—a Catholic hospital system that stood to lose over $900 million annually—sued HHS, alleging among other things that the transgender mandate violated RFRA.

In December 2016, a district court preliminarily enjoined enforcement of the transgender mandate nationwide, in part because it likely substantially burdened CMDA's and Franciscan's religious exercise. *Franciscan All., Inc.* v. *Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016). The court later granted summary judgment to CMDA and Franciscan on their RFRA

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[7] CMDA Ethics Statement: Transgender Identification (adopted Oct. 30, 2021), https://perma.cc/2BNS-7BTN. The 2016 version of this statement, which expresses the same beliefs, was cited in the transgender mandate litigation.

[8] *Ibid.*

claim and vacated the transgender mandate's provisions requiring CMDA members to perform, refer for, or cover gender transitions. *Franciscan All., Inc.* v. *Azar*, 414 F. Supp. 3d 928, 944 (N.D. Tex. 2019).

Victory was brief. CMDA asked the Fifth Circuit for a permanent injunction addressing any effort by HHS to require its members to perform the objectionable procedures, not just the partial vacatur granted by the district court. But while the appeal was pending, HHS removed the 2016 sex-discrimination definition and incorporated Title IX's religious exemption into a "new" rule. 85 Fed. Reg. 37,160, 37,162 (June 19, 2020). It then told the Fifth Circuit that CMDA's case was moot under both the new rule and this Court's *Bostock* decision, and the Fifth Circuit remanded for consideration of these issues. *Franciscan All., Inc.* v. *Becerra*, 843 Fed. Appx. 662 (5th Cir. 2021).

HHS then published more Section 1557 guidance, eschewing RFRA yet again and confirming that its "new" approach was simply a repackaged version of the 2016 transgender mandate.[9] Correctly finding the 2020 rule "materially indistinguishable from the 2016 Rule," the district court issued a permanent injunction. *Franciscan All., Inc.* v. *Becerra*, 553 F. Supp. 3d 361, 373-378 (N.D. Tex. 2021). The Fifth Circuit affirmed, despite HHS's continued cries of mootness. *Franciscan All., Inc.* v. *Becerra*, 47 F.4th 368, 376-380

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[9] HHS, *Notification of Interpretation and Enforcement of Section 1557 of the Affordable Care Act and Title IX of the Education Amendments of 1972* (May 10, 2021), https://perma.cc/9TEW-FA6R (noting RFRA only to say that OCR "will comply with" it).

(5th Cir. 2022). HHS chose not to petition for certiorari.[10]

One might think this would bring to an end the transgender mandate saga—and with it, HHS's cold war on RFRA. Not so. In 2022, HHS once again published proposed rules that would require healthcare professionals to offer gender transition services regardless of their religious beliefs. 87 Fed. Reg. 47,824 (Aug. 4, 2022). Yet again, instead of considering RFRA or providing a religious exemption, HHS offers a vague reassurance it will "comply with" RFRA down the road—a troubling proposition in light of its track record and continued insistence that its rules address a compelling government interest. *Id*. at 47,895.[11]

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[10] Similar litigation—filed by the Religious Sisters of Mercy, a Catholic order of nuns who run health clinics to care for the elderly and poor—proceeded along a parallel track in North Dakota, leading to the same outcome. There, the district court "declare[d] that HHS's interpretation of Section 1557 that requires the Catholic Plaintiffs to perform and provide insurance coverage for gender-transition procedures violates their sincerely held religious beliefs without satisfying strict scrutiny under the RFRA" and permanently enjoined enforcement against the plaintiffs. *Religious Sisters of Mercy* v. *Azar*, 513 F. Supp. 3d 1113, 1153 (D.N.D. 2021) (capitalization altered), aff'd, *Religious Sisters of Mercy* v. *Becerra*, 55 F.4th 583 (8th Cir. 2022). There, too, HHS chose not to petition for certiorari.

[11] And once again, CMDA and healthcare professionals told HHS that its rule leaves religious freedom unprotected. See Christian Med. & Dental Ass'n, Comment Letter on Nondiscrimination in Health Programs and Activities (Oct. 1, 2022), https://perma.cc/NAJ2-5FRB; Muslim Religious Freedom All., Comment Letter on Nondiscrimination in Health Programs and Activities (Sept. 22, 2022), https://perma.cc/6NPA-E6J4; U.S. Conf. of Catholic Bishops, Comment Letter on Nondiscrimination

All told, CMDA rode a six-year litigation roller coaster simply to resolve a burden on its religious rights that was clear the day HHS issued the transgender mandate. All of that could have been avoided if HHS had *actually* considered and credited healthcare professionals' religious rights in the first place. And HHS's most recent actions—the proposed rule that has yet to be finalized—indicate that what's past is prologue.

* * *

There are many lessons to be drawn from HHS's continuing attempts to mandate contraception coverage and gender transitions across the country. Perhaps the most relevant here is this: HHS is acutely aware of "the potential for conflict" between healthcare regulations and RFRA. *Little Sisters*, 140 S. Ct. at 2383. It is also aware of the protracted litigation that results when it seeks to evade RFRA's requirements. And yet it is undeterred.

C. The EMTALA guidance is unlawful because it completely ignores RFRA.

HHS made no attempt to reconcile its EMTALA guidance with RFRA. Indeed, it didn't even proceed through the normal regulatory process, during which it would have inevitably been informed—yet again—of the serious free exercise implications of its approach. Instead, HHS circumvented notice-and-comment rulemaking altogether, issuing a perfunctory guidance document that spares not a word explaining how it

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in Health Programs and Activities (Sept. 7, 2022), https://perma.cc/CDQ3-EGXX.

could possibly "implement[]" EMTALA in this fashion while also complying with RFRA.

Nor could it. Even if HHS had authority under EMTALA to issue the guidance and skip notice-and-comment rulemaking—it didn't, as the Fifth Circuit has already held, see *Texas* v. *Becerra*, 89 F.4th 529, 541-542, 545-546 (5th Cir. 2024)—the guidance would still fail because it cannot satisfy RFRA's robust protections.

First, HHS cannot seriously dispute that the guidance imposes a substantial burden on the many healthcare professionals whose religious beliefs compel them not to participate in abortion. The guidance requires participating hospitals with emergency departments and their physicians and staff to provide abortions to women in certain circumstances, including where a patient presents "with an incomplete medical abortion." Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Services, Guidance Document QSO-22-22-Hospitals (July 11, 2022), Legislature Br. App.31.

For members of CMDA and numerous other religious healthcare professionals, compliance with this guidance would directly contravene their sincerely held religious beliefs. But if the hospital or doctor refuses to comply, they risk severe financial penalties to the tune of $120,000 per violation. Legislature Br. App.42. Taking a page from the transgender mandate playbook, the EMTALA guidance excludes noncompliant healthcare professionals from participating in Medicare and Medicaid and threatens to terminate the hospital's provider agreement, *ibid*., which for many would sound the death knell of their practice. The

guidance then goes one step further, purporting to create a private right of action under applicable state personal injury laws. *Ibid.*

Because the guidance forces religious objectors "to pay an enormous sum of money * * * if they insist on * * * [following] their religious beliefs," there is no question that it "clearly imposes a substantial burden on those beliefs." *Hobby Lobby*, 573 U.S. at 726; see also *Sharpe Holdings, Inc.* v. *U.S. Dep't of Health & Hum. Servs.*, 801 F.3d 927, 938 (8th Cir. 2015) ("[w]hen the government imposes a direct monetary penalty to coerce conduct that violates religious belief, '[t]here has never been a question' that the government 'imposes a substantial burden on the exercise of religion.'"); *Franciscan All.,* 227 F. Supp. at 691-692 (the transgender mandate imposed a substantial burden by making "'religious beliefs more expensive' in the context of business activities" (quoting *Hobby Lobby*, 573 U.S. at 710)); *Religious Sisters of Mercy* v. *Azar*, 513 F. Supp. 3d 1113, 1147 (D.N.D. 2021) (finding a substantial burden because "practical consequences abound" from noncompliance with the transgender mandate).

Second, because the guidance infringes free exercise rights, it can survive only if HHS carries its burden under strict scrutiny, "the most demanding test known to constitutional law." *City of Boerne* v. *Flores*, 521 U.S. 507, 534 (1997); see also *Hobby Lobby*, 573 U.S. at 728 ("exceptionally demanding" test). Under that test, HHS must show that its guidance furthers a compelling interest using the least restrictive means. 42 U.S.C. 2000bb-1(b). The EMTALA guidance does neither.

To show a compelling interest, HHS must demonstrate that its guidance furthers an interest "of the highest order." *Church of Lukumi Babalu Aye, Inc.* v. *City of Hialeah*, 508 U.S. 520, 546 (1993). It must make this showing not "in the abstract" but "*in the circumstances of this case*." *California Democratic Party* v. *Jones*, 530 U.S. 567, 584 (2000). HHS can clear this high bar only if it can show that the absence of an abortion mandate for religious healthcare providers constitutes "the gravest abuse[]" of its responsibilities. *Sherbert* v. *Verner*, 374 U.S. 398, 406 (1963).

HHS cannot come close to meeting this exacting test. First and most obviously, EMTALA says absolutely nothing on the subject of abortion, while explicitly providing for care that protects the "health" of an "unborn child." 42 U.S.C. 1395dd(e)(1)(A)(i), (B)(ii). This anomaly raises the question: "[I]f Congress thought that there was a compelling need to provide" abortions as emergency care, "why didn't Congress mandate that [provision] in [EMTALA] itself?" *Little Sisters*, 140 S. Ct. at 2392 (Alito, J., concurring).

The agency's decades of silence also speak volumes. As petitioners rightly emphasize, EMTALA existed for 36 years without the government ever even nodding toward the idea that the statute's purposes could not be achieved without an abortion mandate. Legislature Br.42, State Br.13. HHS cannot explain how a "compelling interest" can suddenly spring to life after the government ignores it for nearly four decades. Nor can HHS point to anything remotely resembling a historical tradition indicating that "paramount" interests would be "endanger[ed]" if the federal government does not require even religious doctors to perform

abortions. *Sherbert*, 374 U.S. at 406; cf. *Dobbs* v. *Jackson Women's Health Org.*, 597 U.S. 215, 241-250 (2022) (recounting the history of abortion laws). In sum, HHS cannot show it has any interest, much less an "interest[] of the highest order," in punishing those who object to providing abortion on religious grounds with severe and potentially career-ending sanctions. *Lukumi*, 508 U.S. at 546.

The guidance also flunks RFRA's "least restrictive means" requirement. *Gonzales* v. *O Centro Espírita Beneficente União do Vegetal*, 546 U.S. 418, 423 (2006). This test requires HHS to "show[] that it lacks other means of achieving its desired goal without imposing a substantial burden on the exercise of religion by the objecting parties." *Hobby Lobby*, 573 U.S. at 728. And "[i]f a less restrictive means is available for the Government to achieve its goals, the Government must use it." *Holt*, 574 U.S. at 365.

Elsewhere in the healthcare context, Congress has repeatedly demonstrated that it is fully capable of achieving its policy objectives while simultaneously protecting the free exercise rights of covered parties, particularly in the area of abortion. For example:

- Initially passed in the 1970s, the Church Amendments prohibit discrimination against those who refuse to perform certain healthcare procedures, including abortion and sterilization, if doing so "would be contrary to [their] religious beliefs or moral convictions." 42 U.S.C. 300a-7(c)(1), (d).
- Enacted in 1996, the Coats-Snowe Amendment prohibits discrimination against any healthcare entity that refuses to facilitate abortions or

train its employees to perform abortions. 42 U.S.C. 238n(a), (c)(2).

- Passed each year since 2004 as an appropriations rider, the Weldon Amendment strips federal funds from any governmental entity that "subjects any institutional or individual healthcare entity to discrimination on the basis that the healthcare entity does not provide, pay for, provide coverage of, or refer for abortions." See, *e.g.*, 2023 Consolidated Appropriations Act, Pub. L. No. 117-328, 507(d)(1), 136 Stat. 4459, 4908-4909 (2022).
- The ACA prohibits discrimination against healthcare professionals who are unwilling to provide, pay for, cover, or make referrals for abortions. 42 U.S.C. 18113, 18023(a)(1), (b)(1)(A), (b)(4).[12]

Put mildly, these protections have not affected HHS's ability to achieve its goals, let alone caused the sky to fall. And they provide long-established examples of less-restrictive models that HHS should have evaluated in a RFRA analysis. *Holt*, 574 U.S. at 368-369 (requiring prison to evaluate other prison policies employing less-restrictive means); see also *McCullen* v. *Coakley*, 573 U.S. 464, 494 (2014) (requiring government to "consider[] different methods that other jurisdictions have found effective" before infringing speech). Had it done so, HHS would have concluded

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[12] These federal laws mirror state protections, with "virtually every state in the country [having] some sort of statute protecting individuals and, in many cases, entities who refuse to provide abortions." Mark L. Rienzi, *The Constitutional Right Not to Kill*, 62 Emory L. J. 121, 148-149 (2012).

that it "must" use these or a similar accommodation under RFRA. *Holt*, 574 U.S. at 365.

Thus, the EMTALA guidance fails RFRA at every step: HHS has substantially burdened the religious exercise of untold numbers of healthcare professionals without showing that it has a compelling interest sufficient to justify the action or that it used the least-restrictive means of achieving that interest. Had HHS engaged in even the most cursory RFRA analysis, it would have concluded that it could not issue this guidance.

II. The EMTALA guidance violates the major questions doctrine.

Failure to consider RFRA is far from the only fatal flaw in the EMTALA guidance. HHS is attempting to override the religious beliefs of all covered hospitals and physicians—on pain of a "huge" and "substantial" noncompliance penalty, *Priests for Life* v. *HHS*, 808 F.3d 1, 19 (D.C. Cir. 2015) (Kavanaugh, J., dissenting from denial of rehearing en banc). That effort implicates a matter of deep political significance. The guidance can therefore be justified only if it is premised on the clearest of statements from Congress. Because that explicit delegation is lacking, the guidance fails under the major questions doctrine.

The major questions doctrine "address[es] a particular and recurring problem: agencies asserting highly consequential power beyond what Congress could reasonably be understood to have granted." *West Virginia* v. *EPA*, 597 U.S. 697, 724 (2022). The doctrine is rooted both in separation of powers principles and "common sense" notions of legislative delegations. *Id.* at 722-723; see also *NFIB* v. *OSHA*, 595 U.S. 109, 124

(2022) (Gorsuch, J., concurring) ("[i]f administrative agencies seek to regulate the daily lives and liberties of millions of Americans, * * * they must at least be able to trace that power back to a clear grant of authority from Congress."); *Biden* v. *Nebraska,* 143 S. Ct. 2355, 2380 (2023) (Barrett, J., concurring) ("Because the Constitution vests Congress with '[a]ll legislative Powers,' a reasonable interpreter would expect it to make the big-time policy calls itself."). Viewed through either lens, the major questions doctrine serves as a pivotal safeguard against executive overreach when agencies attempt to regulate in areas of vast "political significance," *FDA* v. *Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 160 (2000).

To apply the major questions doctrine, courts examine in "context" the "history and the breadth of the authority that the agency has asserted, and the economic and political significance of that assertion" to ensure that Congress indeed intended "to confer on [the agency] such vast authority." *West Virginia*, 597 U.S. at 721 (cleaned up); see *id.* at 749 (Gorsuch, J., concurring). Relevant context includes "the nature of the question presented," *id.* at 721, and whether it "has been the subject of an earnest and profound debate across the country," *Gonzales* v. *Oregon*, 546 U.S. 243, 267 (2006) (cleaned up); *West Virginia*, 597 U.S. at 732. Courts also consider the agency's prior interpretations of the questioned provision—particularly if the new interpretation deviates from the agency's longstanding views. See, *e.g.*, *Biden*, 143 S. Ct. at 2361; *NFIB*, 595 U.S. at 119; *Alabama Ass'n of Realtors* v. *HHS*, 141 S. Ct. 2485, 2487 (2021). Other statutes addressing the same issue also inform the contextual analysis. See, *e.g.*, *Brown & Williamson*, 529 U.S.

at 143-144. If this "context" does not provide a "clear delegation" from Congress, then the regulatory action is invalid. *Biden*, 143 S. Ct. at 2374; see also *id.* at 2376 (Barrett, J., concurring) (major questions doctrine "emphasize[s] the importance of context when a court interprets a delegation to an administrative agency").

Here, the absence of "clear authorization" is perhaps the most obvious, as there can be no serious dispute that Congress did not grant HHS *any* authority to impose its abortion mandate. As petitioners ably demonstrate, Legislature Br.42-45; State Br.21-23, EMTALA not only lacks a "clear congressional authorization" to impose an abortion requirement, *Utility Air Regul. Grp.* v. *EPA*, 573 U.S. 302, 324 (2014), it is utterly silent on the question of what if any standards of medical care it imposes on covered parties, Legislature Br.7; State Br.24-32.

It also can't be seriously disputed that the guidance raises a major question. As explained at pp. 18-19, supra, HHS's newly discovered abortion requirement plainly infringes on the religious exercise rights of the many hospitals and individual physicians who object to performing or participating in abortion. This fact more than suffices to show that the regulation involves a major question.

That's because, put simply, religious exercise is a major question. Requiring clear authorization from Congress before imposing religious burdens comports with the historical judicial protection for natural rights like religious liberty. Both before and at the Founding, courts used "equitable interpretation * * * , which entails the narrow construction of

statutes so as to avoid violations of natural rights." Michael W. McConnell, *The Ninth Amendment in Light of Text and History*, 2009-2010 Cato Sup. Ct. Rev. 13, 18. This approach meant that "natural rights control in the absence of sufficiently explicit positive law to the contrary," which can be viewed "as a clear statement rule for abrogating unenumerated natural rights." *Ibid.*

Moreover, this Court has also recognized that the major questions doctrine applies when Congress asserts broad authority over areas enjoying a "unique place in American history and society," *Brown & Williamson*, 529 U.S. at 159, of which this nation's "first freedom" is a preeminent example. *Roman Catholic Diocese of Brooklyn* v. *Cuomo*, 592 U.S. 14, 23 (2020) (Gorsuch, J., concurring). Because the EMTALA guidance imposes "profound burdens" on the "individual right[]"of free exercise without a clear delegation from Congress, it cannot stand. *Biden*, 143 S. Ct. at 2374-2375.

The litany of other federal legislation concerning religious objections to abortion confirms that Congress is acutely aware of the religious exercise infringements that can result from abortion regulation, see *Brown & Williamson*, 529 U.S. at 143-144, "ma[king] it very unlikely that Congress" delegated to HHS the ability to mandate participation in abortion through EMTALA, *West Virginia*, 597 U.S. at 723; see pp. 21-22, *supra* (listing legislative protections). Indeed, as HHS itself said elsewhere, "Congress has enacted numerous statutes to protect freedoms of conscience and religious exercise in the health-care context," particularly in the area of abortion. Brief of U.S. Dep't of HHS at 3, *New York* v. *HHS*, No. 19-4254 (2d Cir. Apr. 27,

2020), ECF No. 157 (discussing the Church Amendments, the Coates-Snow Amendment, the Weldon Amendment, and the Affordable Care Act). This legislative backdrop provides further context "as to the manner in which Congress" regulates abortion in the healthcare context, *West Virginia*, 597 U.S. at 722-723, and shows how unlikely it is that Congress granted HHS the authority to superimpose an abortion requirement onto EMTALA. See also *Biden*, 143 S. Ct. at 2384 (Barrett, J., concurring) (explaining that the major questions doctrine avoids "interpret[ing] a statute for all it is worth when a reasonable person would not read it that way").

But the obvious free exercise implications are far from the only contextual clue leading to the inescapable conclusion that a major question exists here. Few questions are more "political[ly] significan[t]" or have engendered more of an "earnest and profound' national debate" than the "national controversy" surrounding abortion, both before and after *Dobbs*. 597 U.S. at 229, 231-232. This debate "makes the oblique form of the claimed delegation all the more suspect." *Gonzalez*, 546 U.S. at 267. And as petitioners also explain, Legislature Br.41; State Br.22, HHS's unheralded interpretation arose after 36 years of dormancy, a "telling indication" that the claimed authority "extends beyond the agency's legitimate reach," *NFIB*, 595 U.S. at 119; see also *West Virginia*, 597 U.S. at 728.

Viewing all these factors together, the EMTALA guidance implicates "both separation of powers principles and a practical understanding of legislative intent," *West Virginia*, 597 U.S. at 723, which shows that "[t]he basic and consequential tradeoffs" inherent in

the guidance "are ones that Congress would likely have intended for itself." *Id*. at 730. Because HHS cannot "point to" any statutory text authorizing its guidance, let alone a "clear" statement authorizing it, the guidance fails. *Id.* at 732.

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HHS knows from long experience that it should consider RFRA. That's especially true when its actions touch on some of the most sensitive and fraught questions in American political and religious life: whether and when someone should participate in an abortion. The guidance flunks the formidable test Congress mandated in RFRA, and Congress never delegated to HHS the authority to do what it has done here.

CONCLUSION

The decision below should be reversed.

Respectfully submitted.

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