

1 XAVIER BECERRA, State Bar No. 118517
 Attorney General of California
 2 JONATHAN WOLFF, State Bar No. 193479
 Chief Assistant Attorney General
 3 JULIE WENG-GUTIERREZ, State Bar No. 179277
 Senior Assistant Attorney General
 4 R. MATTHEW WISE, State Bar No. 238485
 Deputy Attorney General
 5 MICHELE L. WONG, State Bar No. 167176
 Deputy Attorney General
 6 KARLI EISENBERG, State Bar No. 281923
 Deputy Attorney General
 7 1300 I Street, Suite 125
 P.O. Box 944255
 8 Sacramento, CA 94244-2550
 Telephone: (916) 324-5360
 9 Fax: (916) 324-5567
 E-mail: Karli.Eisenberg@doj.ca.gov
 10 *Attorneys for Plaintiff State of California, by and
 through Attorney General Xavier Becerra*

11 IN THE UNITED STATES DISTRICT COURT
 12 FOR THE NORTHERN DISTRICT OF CALIFORNIA
 13

14
 15
 16 **STATE OF CALIFORNIA, BY AND
 THROUGH ATTORNEY GENERAL XAVIER
 17 BECERRA,**

18 Plaintiff,

19 v.

20
 21 **DON J. WRIGHT, IN HIS OFFICIAL
 CAPACITY AS ACTING SECRETARY OF THE
 U.S. DEPARTMENT OF HEALTH & HUMAN
 22 SERVICES; U.S. DEPARTMENT OF
 HEALTH AND HUMAN SERVICES; R.
 23 ALEXANDER ACOSTA, IN HIS OFFICIAL
 CAPACITY AS SECRETARY OF THE U.S.
 24 DEPARTMENT OF LABOR; U.S.
 DEPARTMENT OF LABOR; STEVEN
 25 MNUCHIN, IN HIS OFFICIAL CAPACITY AS
 SECRETARY OF THE U.S. DEPARTMENT OF
 26 THE TREASURY; U.S. DEPARTMENT OF
 THE TREASURY; DOES 1-100,**

27 Defendants.
 28

**COMPLAINT FOR DECLARATORY
 AND INJUNCTIVE RELIEF**

INTRODUCTION

1
2 1. Ensuring women access to preventive health care, including contraception, is a key
3 element in shaping women's overall health and well-being, and is therefore a critical component
4 of the State's public health programs. Contraceptives are among the most widely used medical
5 services in the United States and are much less costly than maternal deliveries for patients,
6 insurers, employers and states, and consequently the use of contraceptives has been shown to
7 result in net savings to women and their employers. Starting in 2012, as part of the Patient
8 Protection and Affordable Care Act (ACA), most group health insurance plans had to cover all
9 Food and Drug Administration (FDA)-approved contraceptive methods without cost-sharing for
10 beneficiaries. 45 C.F.R. § 147.130(a)(1)(iv); 29 C.F.R. § 2590.715-2713(a)(1)(iv); 26 C.F.R.
11 § 54.9815-2713(a)(1)(iv). Since this contraceptive-coverage requirement took effect, women
12 have saved \$1.4 billion.

13 2. On October 6, 2017, the U.S. Health and Human Services (HHS), in conjunction with
14 the U.S. Department of Labor and U.S. Department of the Treasury, issued two illegal interim
15 final rules (IFRs), 2017-21851 and 2017-21852. The IFRs drastically change access to
16 contraceptive coverage by expanding the scope of the religious exemption to, among other things,
17 allow *any* employer or health insurer with religious *or* moral objections to opt out of the
18 contraceptive-coverage requirement with no assurances that the federal government will provide
19 critical oversight to ensure coverage. Unlike the prior regulations, the IFRs guarantee that there is
20 no longer an automatic seamless mechanism for women to continue to receive contraceptive
21 coverage if their employer opts out. Further, under this new regime, there is not even a
22 requirement that the employer notify the federal government of a decision to stop providing
23 contraceptive coverage. Therefore, millions of women in California may be left without access to
24 contraceptives and counseling and the State will be shouldering that additional fiscal and
25 administrative burden as women seek access for this coverage through state-funded programs.

26 3. The State of California, by and through Attorney General Xavier Becerra, challenges
27 the illegal IFRs and seeks an injunction to prevent the IFRs from taking effect because the
28 regulations violate the Administrative Procedure Act (APA), the Establishment Clause of the First

1 Amendment, and the Equal Protection Clause of the Fifth Amendment. Furthermore, the
2 issuance of the IFRs will have immediate and irreparable harm on the State.

3 **JURISDICTION AND VENUE**

4 4. This Court has jurisdiction pursuant to 28 U.S.C. § 1331 (action arising under the
5 laws of the United States), 28 U.S.C. § 1361 (action to compel officer or agency to perform duty
6 owed to Plaintiff), and 5 U.S.C. §§ 701-706 (Administrative Procedure Act). An actual
7 controversy exists between the parties within the meaning of 28 U.S.C. § 2201(a), and this Court
8 may grant declaratory relief, injunctive relief, and other relief pursuant to 28 U.S.C. §§ 2201-
9 2202 and 5 U.S.C. §§ 705-706.

10 5. Defendants' issuance of the IFRs on October 6, 2017, constitutes a final agency
11 action and is therefore judicially reviewable within the meaning of the Administrative Procedure
12 Act. 5 U.S.C. §§ 704, 706.

13 6. Venue is proper in this Court pursuant to 28 U.S.C. § 1391(e) because this is a
14 judicial district in which the State of California resides and this action seeks relief against federal
15 agencies and officials acting in their official capacities.

16 **INTRADISTRICT ASSIGNMENT**

17 7. Pursuant to Civil Local Rules 3-5(b) and 3-2(c), there is no basis for assignment of
18 this action to any particular location or division of this Court.

19 **PARTIES**

20 8. Plaintiff, the State of California, by and through Attorney General Xavier Becerra,
21 brings this action. The Attorney General is the chief law enforcement officer of the State and has
22 the authority to file civil actions in order to protect public rights and interests. Cal. Const., art. V,
23 § 13. This challenge is brought pursuant to the Attorney General's independent constitutional,
24 statutory, and common law authority to represent the public interest.

25 9. The State of California has an interest in ensuring women's health care is both
26 available and accessible. Health care is one of the police powers of the States. California relies
27 on Defendants' compliance with the procedural and substantive requirements of the APA in order
28 to obtain timely and accurate information about activities that may have significant adverse

1 impacts on access to health care, including contraceptive coverage, and to meaningfully
2 participate in an impartial and public decision-making process that is consistent with the scope of
3 the Affordable Care Act's requirements of free contraceptive coverage.

4 10. California is aggrieved by the actions of Defendants and has standing to bring this
5 action because of the injury to its state sovereignty caused by Defendants' issuance of the illegal
6 IFRs, including immediate and irreparable injuries to its sovereign, quasi-sovereign, and
7 proprietary interests. In particular, California will suffer concrete and substantial harm because
8 the IFRs frustrate California's public health interests by curtailing women's access to
9 contraceptive care through employer-sponsored health insurance, and will burden the State with
10 increased costs of providing contraceptive coverage and costs resulting from unintended
11 pregnancies.¹

12 11. Defendant Don. J. Wright is Acting Secretary of HHS and is sued in his official
13 capacity. Acting Secretary Wright has responsibility for implementing and fulfilling HHS's
14 duties under the Constitution, the ACA, and the APA.

15 12. Defendant HHS is an agency of the United States government and bears
16 responsibility, in whole or in part, for the acts complained of in this Complaint. The Centers for
17 Medicare and Medicaid Services is an entity within the HHS.

18 13. Defendant R. Alexander Acosta is Secretary of the U.S. Department of Labor and is
19 sued in his official capacity. Secretary Acosta has responsibility for implementing and fulfilling
20 the U.S. Department of Labor's duties under the Constitution, the ACA, and the APA.

21 14. Defendant U.S. Department of Labor is an agency of the United States government
22 and bears responsibility, in whole or in part, for the acts complained of in this Complaint. The
23 Employee Benefits Security Administration is an entity within the U.S. Department of Labor.

24 15. Defendant Steven Mnuchin is Secretary of the U.S. Department of the Treasury and is
25 sued in his official capacity. Secretary Mnuchin has responsibility for implementing and

26
27 ¹ Though this complaint focuses on how the IFRs target women, the IFRs also may affect
28 people who do not identify as women, including some gender non-confirming people and some
transgender men.

1 fulfilling the U.S. Department of the Treasury's duties under the Constitution, the ACA, and the
2 APA.

3 16. Defendant U.S. Department of the Treasury is an agency of the United States
4 government and bears responsibility, in whole or in part, for the acts complained of in this
5 Complaint. The Internal Revenue Service (IRS) is an entity within the U.S. Department of the
6 Treasury.

7 **STATUTORY BACKGROUND**

8 **I. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT**

9 17. The ACA requires that certain group health insurance plans cover preventive care and
10 screenings without imposing costs on the employee and his/her covered dependents. 42 U.S.C.
11 § 300gg-13(a). Importantly, this includes women's "preventive care and screenings . . . as
12 provided for in comprehensive guidelines supported by the Health Resources and Services
13 Administration." 42 U.S.C. § 300gg-13(a)(4). During the 2009 debates leading up to the ACA's
14 passage, the United States Congress specifically proposed an amendment to require health plans
15 to cover comprehensive women's preventive care and screenings. This amendment, which came
16 to be called the Women's Health Amendment, relied on guidelines developed by the independent,
17 nonpartisan Institute of Medicine (IOM) and adopted by the HHS. It required coverage for
18 "preventive care and screenings" for women to ensure "essential protections for women's access
19 to preventive health care not currently covered in other prevention section of the [ACA]."

20 18. The IOM assembled a diverse, expert committee to draft a report to determine what
21 should be included in cost-free "preventive care" coverage for women. The report underwent
22 rigorous, independent external review prior to its release.

23 19. On or about July 19, 2011, the IOM issued its expert report which included a
24 comprehensive set of eight evidence-based recommendations for strengthening preventive health
25 care services. Specifically, the IOM recommended that private health insurance plans be required
26 to cover all contraceptive benefits and services approved by the FDA without cost-sharing (also
27 known as out-of-pocket costs such as deductibles and copays).

28

1 20. These IOM recommendations, developed after an exhaustive review of the medical
2 and scientific evidence, were intended to fill important gaps in coverage. The recommendations
3 include coverage for an annual well-woman preventive care visit, specific services for pregnant
4 women and nursing mothers, counseling and screening for HIV and domestic violence, as well as
5 services for the early detection of reproductive cancers and sexually transmitted infections.
6 Significantly, the recommendations include coverage of the full range of all FDA-approved
7 contraceptive methods, sterilization procedures, and patient education and counseling for all
8 women with reproductive capacity. The IOM acknowledged the reality that cost can be a
9 daunting barrier for women when it comes to choosing and using the most effective contraceptive
10 method. For instance, certain highly-effective contraceptive methods, such as the intrauterine
11 device and the implant, have high up-front costs, which act as a barrier to access despite the fact
12 that these contraceptives are long-acting and 99 percent effective. The IOM considers these
13 services essential so that “women can better avoid unwanted pregnancies and space their
14 pregnancies to promote optimal birth outcomes.”

15 21. Thus, the IOM recommended that “preventive care” include not only contraceptive
16 coverage such as access to all FDA-approved contraceptives but also counseling and education to
17 ensure that women were receiving information on the best method for their individual set of
18 circumstances.

19 22. Following the IOM’s recommendations relating to contraceptive coverage, HHS, the
20 U.S. Department of Labor, and the U.S. Department of the Treasury promulgated regulations
21 requiring that group health insurance plans cover all FDA-approved contraceptive methods
22 without cost to women and their covered dependents. 45 C.F.R. § 147.130(a)(1)(iv); 29 C.F.R.
23 § 2590.715-2713(a)(1)(iv); 26 C.F.R. § 54.9815-2713(a)(1)(iv).

24 23. In implementing this statutory scheme, HHS made clear that these coverage
25 requirements were not applicable to group health plans sponsored by religious employers.
26 Further, HHS made available to health plans a religious accommodation to employers who seek
27 to not provide this coverage. Through this religious accommodation, the federal government
28 ensured that women had access to seamless contraceptive coverage as entitled under the ACA,

1 while also providing employers with a mechanism to opt-out of providing or paying for this
2 coverage.

3 24. In order to effectuate this policy, the Health Resources and Services Administration
4 (HRSA) issued guidelines implementing the IOM's expert report's recommendations. These
5 guidelines ensure that women receive a comprehensive set of preventive services without having
6 to pay a co-payment, co-insurance, or a deductible.

7 25. HRSA's comprehensive guidelines included a list of each type of preventive service,
8 and the frequency with which that service should be offered. Under the guidelines, HHS
9 recognized that well-woman visits should be conducted annually for adult women to obtain the
10 recommended preventive services that are age- and development-appropriate, including
11 preconception care and many services necessary for prenatal care. HRSA recognized that the
12 well-woman health screening should occur at least on an annual basis, but also noted that several
13 visits may be needed to obtain all necessary recommended preventive services, depending on a
14 woman's health status, health needs, and other risk factors. HRSA's guidelines also included
15 annual counseling on sexually transmitted infections for all sexually active women, annual
16 counseling and screening for human immunodeficiency virus infection for all sexually active
17 women, all FDA-approved contraceptive methods, sterilization procedures, and patient education
18 and counseling for all women with reproductive capacity. These guidelines ensured that women
19 could access a comprehensive set of preventive services without having to pay a co-payment, co-
20 insurance, or a deductible to ensure there was no cost barrier.

21 26. In March 2016, HRSA awarded a five-year cooperative agreement to the American
22 Congress of Obstetricians and Gynecologists (ACOG) to update the women preventive services
23 guidelines originally recommended by IOM and work to develop additional recommendations to
24 enhance women's overall health. In that same month, ACOG launched the "Women's Preventive
25 Services Initiative" (WPSI), which was a multidisciplinary steering committee headed by ACOG
26 to update the eight IOM recommendations from 2011. Through this initiative, ACOG partnered
27 with the American Academy of Family Physicians, the American College of Physicians, and the
28 National Association of Nurse Practitioners in Women's Health to achieve this goal. The WPSI

1 issued draft recommendations for public comments in September of 2016 and the updated
2 “Women’s Preventive Service Guidelines” were finalized and implemented by HRSA on
3 December 20, 2016 to take effect December 20, 2017. Importantly, these expert, evidence-based
4 medical recommendations continued to include coverage of all FDA-approved contraceptive
5 methods and counseling for women with reproductive capacity, underscoring their importance to
6 women.

7 **II. ADMINISTRATIVE PROCEDURE ACT**

8 27. Pursuant to the Administrative Procedure Act (APA), 5 U.S.C. § 551 *et seq.*, a
9 reviewing court shall “(1) compel agency action unlawfully withheld or unreasonably delayed;
10 and (2) hold unlawful and set aside agency action, findings, and conclusions found to
11 be ...arbitrary, capricious, an abuse of discretion, otherwise not in accordance with law; [or]
12 without observance of procedure required by law.” 5 U.S.C. § 706. The APA defines “agency
13 action” to include “the whole or a part of an agency rule, *order*, license, sanction, relief, or the
14 equivalent or denial thereof, or failure to act.” *Id.* § 551(13) (emphasis added); *see id.* § 551(6)
15 (defining “order” to mean “the whole or a part of a final disposition, whether affirmative,
16 negative, injunctive, or declaratory in form, of an agency in a matter other than rule making but
17 including licensing”).

18 **FACTUAL AND PROCEDURAL BACKGROUND**

19 **I. CONTRACEPTIVE COVERAGE**

20 28. Contraceptives are among the most widely used medical products in the United
21 States, with 99 percent of sexually active women having used at least one type of contraception in
22 her lifetime. By the age of 40, American women have used an average of three or four different
23 methods (some of which are available only by prescription), after considering their relative
24 effectiveness, side effects, drug interactions and hormones, the frequency of sexual conduct,
25 perceived risk of sexually transmitted infections, the desire for control, and a host of other factors.
26 Of course, women face the possibility of having children for many years of their life and therefore
27 if a woman only wants two children, for instance, she would need to spend roughly three decades
28 on birth control to avoid unintended pregnancies. Due to the positive impact of contraception for

1 women and society, the Centers for Disease Control and Prevention concluded that family
2 planning, including access to modern contraception, was one of the ten greatest achievements of
3 the 20th Century. Further, one-third of the wage gains women have made since the 1960s are the
4 result of access to oral contraceptives. Access to birth control has helped narrow the wage gap
5 between women and men. The decrease in the wage gap among 25 to 49-year-olds between
6 men's and women's annual incomes would have been 10 percent smaller in the 1980s and 30
7 percent smaller in the 1990s in the absence of widespread legal birth control access for women.

8 29. Contraceptives are much less costly than maternal deliveries for states, insurers,
9 employers, and patients, and consequently, they have been shown to result in net savings to
10 women and ultimately employers. The ACA's requirement to cover contraception benefits and
11 services has saved American women \$1.4 billion since the law took effect in 2012. For instance,
12 the share of women of reproductive age who had out-of-pocket spending on oral contraceptive
13 pills fell sharply after the ACA; spending on oral contraceptive pills plummeted from 20.9
14 percent in 2012 to 3.6 percent in 2014, corresponding to the timing of the ACA provision. To
15 date, over 62.4 million women have benefited from this coverage, including 13 million in
16 California. Although both men and women benefit from access to safe and reliable contraceptive
17 care, women disproportionately bear the cost of obtaining contraceptives. This is in part because,
18 of the FDA-approved methods of contraceptives, only two—male sterilization surgery and male
19 condoms—are available for use by men. The methods of contraception at issue in this matter are
20 only available for women.

21 30. This savings to women has a corresponding fiscal impact on society, including to the
22 State of California. The ACA's contraceptive-coverage requirement decreases the number of
23 unintended pregnancies, and thereby the costs associated with those pregnancies. Furthermore,
24 unintended pregnancy is associated with poor birth outcomes and maternal health issues, and
25 thus, the contraceptive-coverage requirement also reduces the number of high-costs births and
26 infants born in poor health.

1 31. In California, 48 percent of all pregnancies were unintended in 2010. Of those
2 unplanned pregnancies that resulted in births, 64.3 percent were publicly funded, costing
3 California \$689.3 million on unintended pregnancies.

4 32. In 2014, the California Legislature passed the Contraceptive Equity Act of 2014 (SB
5 1053), which requires certain health plans to cover certain prescribed FDA-approved
6 contraceptives for women without cost-sharing. Twenty-seven other states have similar
7 contraceptive equity laws, aimed at making contraception cheaper and more accessible.

8 33. In passing the Contraceptive Equity Act, the California Legislature concluded that
9 providing contraception will result in overall savings in the health care industry due to reduced
10 office visits, reduced unintended pregnancies, and therefore, reduced prenatal care, abortions, and
11 labor and delivery costs. In fact, the California Health Benefits Review Program (CHBRP)
12 anticipated that there would be substantial cost savings, including \$213 million in savings to
13 private employers, \$86 million in savings to individuals, and \$7 million in savings to CalPERS.
14 CHBRP also anticipated a cost savings of \$56 million for Medi-Cal managed care. In addition to
15 these fiscal benefits, there is huge benefit to California's public health. CHBRP estimated that
16 access to and increased contraceptive use under this act would result in 51,298 averted unintended
17 pregnancies, and among those averted, CHBRP estimated that 20,006 averted abortions.
18 Moreover, with the decrease in unintended pregnancies and abortions, there is a corresponding
19 decrease in the risk of maternal mortality, adverse child outcomes, behavior problems in children,
20 and negative psychological outcomes associated with unintended pregnancies for both mothers
21 and children. Significantly, access to contraceptive coverage helps women to delay childbearing
22 and pursue additional education, spend additional time in their careers, and have increased
23 earning power over the long-term.

24 34. California's Contraceptive Equity Act, however, only applies to state-regulated health
25 plans. It does not apply to self-funded health plans, through which 61 percent of covered workers
26 are insured. Self-funded health plans are governed by the Federal Employee Retirement Income
27 Security Act of 1974 and are regulated by the U.S. Department of Labor, Employee Benefits
28 Security Administration.

1 35. The California Health Care Foundation estimates that as of 2015, 6.6 million
2 Californians were covered by a self-funded employer health plan. Therefore, the IFRs could
3 affect over 6 million California women. These women will be left unprotected and the IFRs
4 threaten California's ability to guarantee health and welfare to its residents by a virtual denial of
5 free access to contraceptive coverage to women.

6 36. In California, if women do not receive cost-free contraceptive coverage from their
7 employer, California risks having to absorb the financial and administrative burden of ensuring
8 access to contraceptive coverage. Due to the IFRs, California women will be forced to utilize the
9 state's Family Planning, Access, Care, and Treatment (Family PACT) program provided they
10 meet certain eligibility requirements. Family PACT is administered by the Office of Family
11 Planning (OFP), an entity within the California Department of Health Care Services, which is
12 charged by the California Legislature to make available to citizens of the State who are of
13 childbearing age comprehensive medical knowledge, assistance, and services relating to the
14 planning of families. Family planning allows women to decide for themselves the number,
15 timing, and spacing of their children.

16 37. Family PACT is available to eligible low-income (under 200 percent of federal
17 poverty level) men and women who are residents of the California. Currently, the program serves
18 1.1 million eligible men and women of childbearing age through a network of 2,200 public and
19 private providers. Services include comprehensive education, assistance, and services relating to
20 family planning. These Californians have no other source of health care coverage for family
21 planning services (or they meet the criteria specified for eligibility with Other Health Coverage)
22 and they have a medical necessity for family planning services.

23 38. The 2,200 clinic and private practice clinician provider entities enroll women in
24 Family PACT across the state. Family PACT clinician providers include private physicians in
25 nonprofit community-based clinics, obstetricians and gynecologists, general practice physicians,
26 family practice, internal medicine, and pediatrics. Medi-Cal licensed pharmacies and laboratories
27 also participate by referrals from enrolled Family PACT clinicians.

28

1 39. Planned Parenthood is one example of a Family PACT provider that enrolls women
2 into the program. Planned Parenthood currently serves approximately 850,000 patients a year
3 through 115 health centers. California reimburses Planned Parenthood for family planning
4 services provided. For every dollar Planned Parenthood spends on family planning services, the
5 federal government contributes 77.49 cents while the state spends 22.51 cents.

6 40. Because health facilities, including but not limited to Planned Parenthood, will likely
7 see a spike in patients seeking contraceptive coverage, California will be fiscally impacted
8 through increased enrollment in Family PACT.

9 **II. PRIOR REGULATORY FRAMEWORK PROVIDING ACA CONTRACEPTIVE-COVERAGE**
10 **REQUIREMENT EXCEPT IN NARROWLY TAILORED CIRCUMSTANCES**

11 41. In enacting and implementing the ACA, both Congress and HHS contemplated laws
12 protecting religious exercise. To that end, the ACA requires no-cost coverage of women's
13 preventive health care, with some narrowly tailored exceptions for those employers that objected
14 to providing their employees with contraceptives. The two exceptions originally implemented
15 were for: (1) religious organizations and (2) nonprofits with religious objections. Specifically, in
16 implementing the ACA, the regulations permit religious employers such as churches to seek an
17 "exemption" from the contraceptive-coverage requirement. *See* 45 C.F.R. § 147.131(a) (current
18 HHS regulation). Nonprofits with religious objections were also allowed to opt out of the
19 contraceptive-coverage requirement via an "accommodation," by which the nonprofit employer
20 certifies its objection and the insurer is then responsible for separate contraceptive coverage.

21 42. Following three rounds of notice-and-comment rulemaking to develop and refine
22 regulations, generating hundreds of thousands of public comments, the federal government
23 enacted this "accommodation" which furthers the compelling interest in ensuring that women
24 covered by every type of health plan receive full and equal health coverage, including
25 contraceptive coverage. At the same time, it ensures that objecting employers are not providing
26 this coverage. Specifically, to obtain the "accommodation," an employer opted out by notifying
27 its insurer using a written form certifying its religious objection and eligibility for the
28 accommodation.

1 43. This process resulted in a relatively seamless mechanism for women, whose
2 employers obtain the religious accommodation, to continue to receive their ACA contraceptive
3 coverage not provided by the employer, and helped the government ensure that no woman was
4 went without birth control as a result. *See* 80 FR 41318 (July 14, 2015) (current HHS regulation);
5 45 C.F.R. § 147.131(c)-(d) (current HHS regulation). This scheme ensured that those employees
6 would not be adversely affected by their employers' decision to opt out. 45 C.F.R. § 147.131(c)-
7 (d). At the same time, it likewise ensured that certain employers who had religious objections
8 could avoid providing for or paying for this coverage. Thus, this scheme struck a good balance
9 for both the employer and the employee.

10 44. The religious accommodation was later expanded to include certain closely-held for-
11 profit organizations with religious objections to providing contraceptive care, consistent with the
12 Supreme Court's decision in *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014); 80 FR
13 41318 (July 14, 2015); 45 C.F.R. § 147.131(b)(4). Further, in response to the Supreme Court, an
14 organization may use an alternative process of providing notice of its religious objections to
15 providing contraceptive services. Instead of filing a form with HHS or sending a copy of the
16 executed form to its health insurance provider or third party administrator, the non-profit
17 organization may use an alternate process to provide notice of its religious objection. It may
18 simply notify HHS in writing of its objection to covering contraceptive coverage. *Wheaton*
19 *College v. Burwell*, 134 S. Ct. 2806 (2014); 80 FR 41318.

20 **III. NEW REGULATORY FRAMEWORK VASTLY EXPANDING THE ABILITY OF**
21 **EMPLOYERS TO OPT-OUT OF PROVIDING COST-FREE CONTRACEPTIVE COVERAGE**
22 **UNDER THE ACA**

23 45. Without any notice, opportunity to comment, or evidence-based expert guidance, on
24 October 6, 2017, Defendants promulgated sweeping new IFRs affecting women's access to cost-
25 free contraceptive coverage. The IFRs fail to address the fact-finding underlying the prior
26 regulations and rely on insufficient evidence.

27 46. Prior to promulgating the IFRs, Defendants failed to meet or convene publically any
28 women's, medical, or public health organizations that emphasize access to health care. For

1 example, Defendants did not meet with the American Academy of Pediatrics, the American
2 Association of Family Physicians, the National Association of Nurse Practitioners in Women's
3 Health, the National Partnership for Women and Families, or the Planned Parenthood Federation
4 of America, among others. Instead, Defendants met with organizations like the Heritage
5 Foundation, Church Alliance, and the Ethics & Religious Liberty Commission of the Southern
6 Baptist Convention.

7 47. The new IFRs vastly expand the scope of entities that may be exempt from the
8 contraceptive-coverage requirement. They cast a wide net beyond religious organizations to any
9 individual, employer or insurer (regardless of corporate structure or religious affiliation), a step
10 that undermines the federally-backed religious accommodation, which balances the interest of
11 employers wishing to opt-out of providing contraception for employees while also ensuring
12 seamless access to care for women. Further, this exemption has been extended to not only a
13 religious objection, but also a new *moral* objection to all or a subset of the contraceptive-coverage
14 requirement.

15 48. The IFRs, thus, expand the *Hobby Lobby* decision to any business with a moral
16 objection against providing women access to contraceptive coverage, further frustrating the
17 scheme and purpose of the ACA.

18 49. Additionally, under the new IFRs, employers seeking to be exempt from providing
19 contraceptives do not need to certify any objection to the coverage requirement. Rather, the
20 employer can simply inform their employees they will no longer cover contraception benefits and
21 counseling as part of their employer health care coverage. This is a significant change. By
22 contrast, the prior federal regulations provided a process for women to receive their care as part of
23 the "religious accommodation," which also ensured that employers who religiously objected to
24 providing this coverage did not have to provide or pay for contraceptives. Under the previous
25 regime, the federal government acted as the guiding entity or the "back-stop" to ensure that there
26 was a balance between the compelling interest that all women have access to their federally
27 entitled benefit under the ACA, while also creating an accommodation for those employers that
28 sought not to provide this coverage. Under the new IFRs there is nothing in place to ensure that

1 women across the country, let alone California, continue to receive this federally entitled
2 coverage. Further, these new IFRs create an entirely new “moral exemption” standard, which
3 was not previously contemplated by the federal government. Employers can simply make use of
4 a religious or the new moral exemption, without informing the federal government, thereby
5 almost ensuring that female employees lose access to this federally entitled seamless
6 contraceptive access as contemplated by the ACA. Without the federal backstop or guidance over
7 a federal entitlement, these women will simply be left without contraceptive coverage and with
8 nowhere to go. The State of California will be forced to fill this gap.

9 50. In short, under the new IFRs, those exempted entities do not need to certify any
10 objection to the contraceptive-coverage requirement to the federal government, which all but
11 ensure that women across the country will go without birth control access as the ACA intended.

12 51. These IFRs could impact 6.6 million Californians who receive their health care
13 through a self-insured employer health plan, and therefore do not receive the benefit of
14 California’s Contraceptive Equity Act.

15 52. There are at least 25 California employers, with 54,879 employees who will likely
16 seek an exemption or accommodation. Thus, an unknown but substantial number of California
17 women will be affected by these IFRs, and under these new IFRs, California anticipates that this
18 number will vastly expand, eviscerating the ability of these women to access cost-free
19 contraceptive coverage through their health plan. Consequently, they will turn to publicly funded
20 clinics or California’s wrap-around family program, Family PACT, to obtain the contraceptive
21 coverage that is no longer being provided by employers or insurers, or being tracked by the
22 federal government to ensure women maintain access as envisioned by the ACA.

23 53. By promulgating the IFRs, California’s concrete interest in ensuring access to
24 contraceptive coverage is violated.

25 **FIRST CAUSE OF ACTION**

26 **(Violation of APA; 5 U.S.C. § 553)**

27 54. Paragraphs 1 through 53 are realleged and incorporated herein by reference.
28

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

- 6. Issue a mandatory injunction prohibiting the implementation of the IFRs;
- 7. Award Plaintiff costs, expenses, and reasonable attorneys' fees;
- 8. Award such other relief as the Court deems just and proper.

Dated: October 6, 2017

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JULIE WENG-GUTIERREZ
Senior Assistant Attorney General

/s/ Karli Eisenberg

/s/ R. Matthew Wise

/s/ Michele L. Wong

KARLI EISENBERG
R. MATTHEW WISE
MICHELE L. WONG
Deputy Attorneys General
*Attorneys for the State of California, by and
through Attorney General Xavier Becerra*

SA2017105979
FINAL Complaint.doc