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**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA**

THE STATE OF CALIFORNIA; THE
STATE OF DELAWARE; THE STATE OF
MARYLAND; THE STATE OF NEW YORK;
THE COMMONWEALTH OF VIRGINIA,

Plaintiffs,

v.

ERIC D. HARGAN, in his official capacity as
Acting Secretary of the U.S. Department of
Health and Human Services; U.S.
DEPARTMENT OF HEALTH AND
HUMAN SERVICES; R. ALEXANDER
ACOSTA, in his official capacity as
Secretary of U.S. Department of Labor; U.S.
DEPARTMENT OF LABOR; STEVEN
MNUCHIN, in his official capacity as
Secretary of the U.S. Department of the
Treasury; U.S. DEPARTMENT OF THE
TREASURY; DOES 1-100,

Defendants,

and,

THE LITTLE SISTERS OF THE POOR
JEANNE JUGAN RESIDENCE,

Defendant-Intervenor.

Case No. 4:17-cv-05783-HSG

**INTERVENOR'S NOTICE OF
MOTION AND MOTION TO
INTERVENE, WITH
MEMORANDUM OF POINTS
AND AUTHORITIES**

Date: February 22, 2018

Time: 2:00 p.m.

Dept.: Courtroom 2

Judge: Hon. Haywood S. Gilliam, Jr.

Date Filed: November 21, 2017

Trial Date: Not yet set

1 **TO THE PARTIES, AND THEIR COUNSEL OF RECORD:**

2 **PLEASE TAKE NOTICE** that on February 22, 2018 at 2:00 p.m., in Courtroom 2 of the
3 above-entitled court, located at 1301 Clay Street, Oakland, the Jeanne Jukan Residence
4 of the Little Sisters of the Poor in San Pedro, California (hereinafter the “Little Sisters”),
5 will and hereby do move this Court to permit them to intervene in this action in order to
6 defend their right to practice their faith free from crippling fines, a right guaranteed to
7 them in *Zubik v. Burwell*, 136 S. Ct. 1557 (2016), and extended to them under a
8 regulation challenged in this action.

9 Pursuant to Federal Rule of Civil Procedure 24, proposed Defendant-Intervenor seeks
10 intervention as of right, or in the alternative, permissive intervention.

11 Simultaneously, the Little Sisters are filing a motion to shorten time so that this
12 motion can be argued and heard when this Court hears arguments on Plaintiffs’ motion
13 for preliminary injunction on December 12, 2017.

14 Plaintiffs oppose both this motion and the motion to shorten time. Defendants take
15 no position on either motion.

16 The Little Sisters have fought for four years for a religious exemption from the
17 crippling fines imposed by the federal government’s contraceptive mandate. That lawsuit
18 is still ongoing. As a direct result of the Little Sisters’ lawsuit, the federal government
19 revised its regulations to exempt the Little Sisters and religious employers like them.
20 But now Plaintiff States are seeking a nationwide injunction to take away the Little
21 Sisters’ religious exemption. The Little Sisters are entitled to intervention as of right
22 because this motion is timely, they have a significant protectable interest that is at stake
23 in this litigation, the relief that Plaintiff States seek would impede their ability to protect

1 that interest, and the current parties will not adequately protect their interest. The
2 Little Sisters are also entitled to permissive intervention because they have a claim
3 which shares a common question of law and fact with Plaintiffs' claims, have
4 independent grounds for jurisdiction, and made a timely motion to intervene.

5 **WHEREFORE**, the Little Sisters pray that this Court grant them intervention in
6 this action. This request is based on this Notice of Motion and Motion, the accompanying
7 supporting Memorandum of Points and Authorities, the supporting declaration of
8 Mother Superior Marguerite Marie McCarthy, as well as the papers, evidence and
9 records on file in this action, and any other written or oral evidence or argument as may
10 be presented at or before the time this motion is heard by the Court. A proposed order is
11 filed herewith.

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INTRODUCTION

For four years, the Little Sisters of the Poor have fought for their right to live out their faith and fulfill their mission of serving the elderly poor without the threat of government fines. The Supreme Court has twice stepped in to protect their rights, most recently directing the Department of Health and Human Services to reconsider its regulations and arrive at a solution that would respect the Little Sisters' religious freedom. Plaintiff States were aware of these ongoing lawsuits, and of the injunctions protecting the Little Sisters, but sat on the sidelines.

As a direct result of the Little Sisters' lawsuit, the federal government revised its regulations to exempt the Little Sisters and religious employers like them. Given those revisions, the Little Sisters had looked forward to putting litigation behind them and focusing on their mission of service. But now Plaintiff States are seeking a nationwide injunction to take away the Little Sisters' religious exemption. In bringing their lawsuit, the States studiously avoided the still-ongoing litigation between the federal government and the religious objectors, not seeking to intervene in the Little Sisters' existing lawsuit, nor in any one of the dozens of other such lawsuits around the country. Nor did the States address themselves to the United States Supreme Court, which has issued an injunction that precludes the nationwide injunction that Plaintiff States seek from this Court. Instead the States engaged in blatant forum shopping, filing their own complaint against the federal government in this Court, apparently afraid to even utter the Little Sisters' name in a lawsuit that is about their rights, not the States'. This is irresponsible political grandstanding of the first order, but comes at the expense of real people—the Little Sisters and the people they serve—who need a real religious exemption.

1 The Little Sisters cannot stand idly by while California and the other States threaten
2 their ministry by trying to snatch away the protections the Sisters have fought so long
3 to keep. This lawsuit seeks to deprive the Little Sisters of the protections provided by
4 the Constitution, federal civil rights laws, and the new regulations, and the Little Sisters
5 are therefore entitled to intervene to defend themselves.

6 STATEMENT OF THE ISSUES

7 Whether the Proposed Defendant-Intervenor should be granted intervention as of
8 right to defend their interests in a lawsuit that threatens legal protections they have
9 won in the U.S. Supreme Court.

10 Alternatively, whether Proposed Defendant-Intervenor should be granted permissive
11 intervention.

12 STATEMENT OF FACTS

13 A. Proposed Intervenor

14 The Jeanne Jugan Residence of the Little Sisters of the Poor in San Pedro, California,
15 is a religious nonprofit corporation operated by an order of Catholic nuns whose faith
16 inspires them to spend their lives serving the sick and elderly poor. Mother Marguerite
17 Decl. ¶¶ 4, 12, 16-17. Each Little Sister takes a vow of obedience to God and of hospitality
18 “to care for the aged as if he or she were Christ himself.” *Id.* at ¶ 36. The Little Sisters
19 treat each “individual with the dignity they are due as a person loved and created by
20 God,” and they strive to “convey a public witness of respect for life, in the hope that [they]
21 can build a Culture of Life in our society.” *Id.* at ¶ 19. The Little Sisters oppose, based
22 on Catholic doctrine, sterilization, contraception, and abortion, and they believe that it
23 is religiously wrong for them to facilitate the provision of those services to their

employees in connection with their health insurance plans. *Id.* at ¶ 37.

B. The Preventive Services Mandate

This case involves the legality of religious exemptions from a regulation mandating employer-provided health coverage for women’s preventive services—*i.e.*, employers with at least 50 full-time employees—must offer a group health plan or group health insurance coverage that provides “minimum essential coverage.” 26 U.S.C. § 5000A(f)(2), 26 U.S.C. § 4980H(a), (c)(2). That “minimum essential coverage” must include, among other things, coverage for “preventive care and screenings” for women. 42 U.S.C. § 300gg-13(a)(4); 29 U.S.C. § 1185d.

Congress did not specify what “preventive care and screenings” means. Instead, Congress delegated that task to the Department of Health and Human Services (“HHS”). *Id.* HHS, in turn, asked the Institute of Medicine (“IOM”) for recommendations, and the IOM recommended that HHS define “preventive care” to include, among other things, “the full range of Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity.” Committee on Preventive Services for Women, Institute of Medicine, *Clinical Preventive Services for Women: Closing the Gap* 109-10 (2011). The FDA-approved contraceptive methods include both drugs and devices that operate to prevent fertilization of an egg, and four drugs and devices—two types of intrauterine devices and the drugs commonly known as Plan B and *ella*—that can prevent implantation of a fertilized egg. Food and Drug Administration, *Birth Control Guide*, <http://bit.ly/2prP9QN>. Only days after the recommendations were published, HHS adopted them entirely in an interim final rule. 76 Fed. Reg. 46,621 (Aug. 3, 2011); 77 Fed.

1 Reg. 8725 (Feb. 15, 2012); 45 C.F.R. § 147.130(a)(1)(iv). None of the Plaintiff States
2 challenged HHS’s authority to adopt the initial preventive services mandate via interim
3 final rule.

4 However, not all private employers are subject to the contraceptive mandate. First,
5 approximately a quarter of large employers are exempt through the ACA’s exception for
6 “grandfathered health plans.” *See* 26 U.S.C. § 4980H(c)(2); 42 U.S.C. § 18011; 75 Fed.
7 Reg. 34,538, 34,542 (June 17, 2010); Kaiser Family Found. & Health Research & Educ.
8 Trust, *Employer Health Benefits 2017 Annual Survey* 204 (2017). Second, even prior to
9 the IFR at issue here, “churches, their integrated auxiliaries, and conventions or
10 associations of churches,” as well as “the exclusively religious activities of any religious
11 order,” 26 U.S.C. § 6033(a)(3)(A)(i), (iii), were exempt from the contraceptive mandate
12 for religious reasons, but other religious employers were not. 82 Fed. Reg. 47,792, 47,795-
13 96 (Oct. 13, 2017).

14 All told, these statutory and regulatory exemptions relieve the employers of tens of
15 millions of employees of any obligation to do anything to comply with the contraceptive
16 mandate—whether or not they have any religious objections to providing such coverage.
17 If employees of exempt employers want to obtain cost-free contraceptive coverage, they
18 must obtain it through alternative means, including through the use of state-funded
19 health care programs. These exemptions have been in place for more than four years,
20 and they apply to tens of millions more people than the IFR at issue here. Yet none of
21 the Plaintiff States has ever filed suit to challenge these exemptions.

22 **C. The Regulatory Mechanism for Complying with the Mandate**

23 Prior to the IFR, religious employers such as the Little Sisters were not exempt from

1 the contraceptive mandate. They needed to either comply with the mandate or pay large
2 fines. *See* 82 Fed. Reg. at 47,795 (exemption limited to small subset of religious
3 employers). The Little Sisters and other religious employers had sought an exemption,
4 but in 2013 HHS refused to grant it and instead offered them only an alternative
5 regulatory mechanism for compliance. *See* 82 Fed. Reg. at 47,795-96. Under that
6 approach, religious entities like the Little Sisters were required to comply with the
7 mandate by signing a required notice to its insurer, third-party administrator (TPA) or
8 the government. If a religious objector complied in this manner, the government would
9 take steps to use their health plan to distribute contraceptives, including use its
10 “insurance coverage network,” its “coverage administration infrastructure,” its
11 information to “verify . . . identit[ies],” and its systems to “provide formatted claims
12 data.” 80 Fed. Reg. 41,318, 41,328-29 (July 14, 2015). In such circumstances, the
13 religious objector would be “considered to comply” with the mandate, 78 Fed. Reg. 39,870,
14 39,879 (July 2, 2013).

15 Unsurprisingly, nonexempt religious employers who hold sincere religious objections
16 to contraception found little solace in this so-called “accommodation” of their religious
17 beliefs. After all, these organizations do not merely object to directing or paying for the
18 inclusion of contraceptive coverage in their plans; they object to being forced to facilitate
19 the provision of contraceptive coverage through their own plan infrastructure as well.
20 Mother Marguerite Decl. ¶ 37. Being forced to comply with the contraceptive mandate
21 via a scheme that requires them to do so is thus no more compatible with their religious
22 beliefs than being forced to comply by writing the coverage into their plans themselves.
23 *Id.* Numerous nonprofit religious employers brought lawsuits challenging application of

1 the contraceptive mandate to them as, among other things, a violation of the Religious
2 Freedom Restoration Act, 42 U.S.C. § 2000bb (“RFRA”). *See* Pet’rs’ Br. at iii-iv, *Little*
3 *Sisters of the Poor Home for the Aged, et al. v. Burwell*, 794 F.3d 1151 (10th Cir. 2015)
4 (No. 15-105). The States in this case filed amicus curiae briefs in some of those cases, but
5 nowhere did they attempt to intervene to protect their purported interests or those of
6 their citizens.

7 **D. Intervenor’s Lawsuit, Supreme Court Orders, and the Interim Final Rule**

8 One of those lawsuits is a class action on behalf of hundreds of Catholic employers
9 who provide health benefits to their employees through the Christian Brothers church
10 plan, including the Little Sisters. Facing the prospect of large penalties starting on
11 January 1, 2014, the plaintiffs filed suit on September 24, 2013, and filed a motion for
12 preliminary injunction one month later, on October 24. *See* Dkts. 1 & 15, *Little Sisters of*
13 *the Poor v. Sebelius*, No. 13-cv-2611 (D. Colo.). The district court denied the motion on
14 December 27, just five days before the start of the penalties. *Id.* at Dkt. 52. The Little
15 Sisters filed an emergency appeal to the Tenth Circuit on the same day, and moved for
16 an injunction pending appeal on December 28. *Id.* at Dkt. 53 & Dkt. 54, *see also*
17 *Emergency Motion for Injunction Pending Appeal, Little Sisters of the Poor v. Burwell*,
18 No. 13-1540 (10th Cir. Dec. 28, 2013). The Tenth Circuit denied the motion on December
19 31, hours before the fines were set to begin. *See* Order, *Little Sisters of the Poor v.*
20 *Burwell*, No. 13-1540 (10th Cir. Dec. 31, 2013).

21 That evening, the Little Sisters filed an emergency application for an injunction
22 under the All Writs Act with the Supreme Court. Shortly before midnight, Justice
23 Sotomayor granted a temporary injunction pending the receipt of a response brief from

1 the defendants. Order, *Little Sisters of the Poor v. Sebelius*, No. 13A691 (Sup. Ct. Dec. 31,
2 2013).

3 On January 24, 2014, the Supreme Court granted a rare injunction pending appeal,
4 without any noted dissent. *Little Sisters of the Poor v. Sebelius*, 134 S. Ct. 1022 (2014).
5 The Court's order provided that:

6 If the employer applicants inform the Secretary of Health and
7 Human Services in writing that they are non-profit
8 organizations that hold themselves out as religious and have
9 religious objections to providing coverage for contraceptive
10 services, the respondents are enjoined from enforcing against
11 the applicants the challenged provisions of the [ACA] and
related regulations pending final disposition of the appeal. . . .
To meet the condition for injunction pending appeal,
applicants need not use the form prescribed by the
Government and need not send copies to third-party
administrators.

12 *Id.*

13 The Tenth Circuit subsequently heard the Little Sisters' appeal and upheld the denial
14 of their injunction. *Little Sisters of the Poor Home for the Aged v. Burwell*, 794 F.3d 1151
15 (10th Cir. 2015). The Little Sisters immediately petitioned for certiorari, which the
16 Supreme Court granted, consolidating their case with several others. *See Zubik v.*
17 *Burwell*, 136 S. Ct. 1557 (2016).

18 A unanimous Supreme Court directed the government to reconsider its regulation
19 and "arrive at an approach going forward that accommodates petitioners' religious
20 exercise while at the same time ensuring that women covered by petitioners' health plans
21 receive full and equal health coverage, including contraceptive coverage." *Id.* at 1560
22 (citation and internal quote omitted). The Supreme Court ordered that "the Government
23 may not impose taxes or penalties on petitioners for failure to provide the relevant

1 notice.” *Id.* at 1561. That order is still in place.

2 The Little Sisters’ case was remanded to the Tenth Circuit, where litigation was
3 stayed, and has remained so while the government reconsiders the exemptions to the
4 HHS Mandate. *See, e.g., Order, Little Sisters of the Poor v. Hargan*, No. 13-1540 (10th
5 Cir. June 27, 2016) (ordering parties to file periodic status reports).

6 On May 4, 2017, President Trump signed an Executive Order related to religious
7 liberty. Exec. Order No. 13,798, 82 Fed. Reg. 21,675 (May 4, 2017). The Executive Order
8 instructed HHS to “consider issuing amended regulations, consistent with applicable
9 law, to address conscience-based objections to the preventive-care mandate
10 promulgated under section 300gg-13(a)(4) of title 42, United States Code.” *Id.*

11 On October 6, HHS complied with that executive order by issuing the Interim Final
12 Rule (“IFR”) at issue in this lawsuit. 82 Fed. Reg. at 47,792. The IFR protects those with
13 religious objections, and expressly refers to the Little Sisters’ lawsuit and the Supreme
14 Court decision in their case as the impetus for the regulatory change: “Consistent with
15 the President’s Executive Order and the Government’s desire to resolve the pending
16 litigation and prevent future litigation from similar plaintiffs, the Departments have
17 concluded that it is appropriate to reexamine the exemption and accommodation scheme
18 currently in place for the Mandate.” 82 Fed. Reg. at 47,799; *see also id.* at 47,798
19 (describing Little Sisters’ lawsuit and *Zubik* decision). HHS stated that “Good cause
20 exists to issue the expanded exemption in these interim final rules in order to cure such
21 violations (whether among litigants or among similarly situated parties that have not
22 litigated), to help settle or resolve cases, and to ensure, moving forward, that our
23 regulations are consistent with any approach we have taken in resolving certain

1 litigation matters.” 82 Fed. Reg. at 47,814.

2 In addition to the multiple previous rounds of public comment on the contraceptive
3 mandate and its exemptions, the IFR set a sixty-day time period for comments, which
4 “provides the public with an opportunity to comment on whether these regulations
5 expanding the exemption should be made permanent or subject to modification.” 82 Fed.
6 Reg. at 47,815. That comment period will end on December 5. In the six weeks since the
7 IFR was issued, the Little Sisters and the government have been in negotiations to
8 resolve the case, but have not yet reached an agreement.

9 **E. This Lawsuit.**

10 On the same day that the IFR was issued, California filed this lawsuit, seeking an
11 injunction against the religious exemption granted by the new rule and the reimposition
12 of penalties on the Little Sisters and other religious objectors. Dkt. 1. On November 1,
13 California filed an amended complaint adding the states of Delaware, Maryland, New
14 York and Virginia as co-plaintiffs. To our knowledge, seven other lawsuits have been
15 filed nationwide. In only two of those lawsuits, including this one, have the plaintiffs
16 filed motions for preliminary injunctive relief. Plaintiffs appear to believe that there is a
17 political aspect to this litigation, as they have not sought interim injunctive relief in any
18 cases assigned to Republican-appointed judges.

19 Although they had failed to intervene in the prior four years of litigation—in which
20 virtually every religious objector had received at least a preliminary injunction
21 protecting them from having to provide contraceptive coverage—the States moved for a
22 preliminary injunction here. The States do not identify even a single actual employer
23 who has been covering contraception and is expected to stop on January 1; nor do the

1 States identify a single actual person who has had such coverage and expects to lose it
2 on January 1. Nevertheless, the States seek an injunction in short order based on claims
3 that the IFR violates the Administrative Procedures Act and that the religious
4 exemptions contained in the IFR violate the Establishment and Equal Protection
5 Clauses of the Constitution. Plaintiffs seek a declaratory judgment that the religious
6 exemptions in the IFR are unlawful, and a nationwide injunction against enforcement of
7 the IFR. If the Plaintiffs are successful, Little Sisters will lose the exemption granted by
8 the IFR, and risk being forced to choose between violating their sincerely held religious
9 beliefs or paying over \$3 million in annual fines. Mother Marguerite Decl. ¶ 43.

10 STANDARD OF REVIEW

11 In evaluating a motion to intervene, district courts are “required to accept as true the
12 non-conclusory allegations” made by the proposed intervenor. *Sw. Ctr. for Biological*
13 *Diversity v. Berg*, 268 F.3d 810, 819 (9th Cir. 2001). Decisions on intervention are “guided
14 primarily by practical considerations, not technical distinctions.” *Citizens for Balanced*
15 *Use v. Montana Wilderness Ass’n*, 647 F.3d 893, 897 (9th Cir. 2011) (quoting *Berg*, 268
16 F.3d at 818). Intervention requirements “are broadly interpreted in favor of
17 intervention.” *Citizens for Balanced Use*, 647 F.3d at 897. Federal Rule of Civil Procedure
18 24(b) instructs courts to “permit anyone to intervene” who “has a claim or defense that
19 shares with the main action a common question of law or fact,” as long as the intervenor
20 has “an independent ground for jurisdiction” and has made a “a timely motion.” Fed. R.
21 Civ. P. 24(b); *Beckman Indus., Inc. v. Int’l Ins. Co.*, 966 F.2d 470, 473 (9th Cir. 1992).

ARGUMENT

I. The Little Sisters are entitled to intervene as of right.

The Little Sisters satisfy all the requirements for intervention as of right. Federal Rule of Civil Procedure 24(a)(2) permits intervention as of right if: “(1) the intervention application is timely; (2) the applicant has a significant protectable interest relating to the property or transaction that is the subject of the action; (3) the disposition of the action may, as a practical matter, impair or impede the applicant’s ability to protect its interest; and (4) the existing parties may not adequately represent the applicant’s interest.” *Citizens for Balanced Use*, 647 F.3d at 897 (citation and internal quotation omitted). These requirements “are broadly interpreted in favor of intervention.” *Id.* at 897. The Little Sisters meet each of the four criteria and should be allowed to intervene as a matter of right.

A. The Little Sisters’ motion is timely.

In determining whether a motion to intervene is timely, the court considers “(1) the stage of the proceeding at which an applicant seeks to intervene; (2) the prejudice to other parties; and (3) the reason for and length of the delay.” *Peruta v. County of San Diego*, 824 F.3d 919, 940 (9th Cir. 2016) (en banc), *cert. denied sub nom. Peruta v. California*, 137 S. Ct. 1995 (2017) (citation and internal quotation omitted). For purposes of this timeliness inquiry, four months after the filing of a lawsuit is still considered “a very early stage,” *Idaho Farm Bureau Fed’n v. Babbitt*, 58 F.3d 1392, 1397 (9th Cir. 1995), and courts regularly find intervention motions to be timely even when filed well after that. *See, e.g., Peruta*, 824 F.3d at 940 (four years).

Here, this case was filed only 45 days ago, defendants have not yet filed any answer, and plaintiffs' preliminary injunction motion was filed just 12 days ago. Given the Little Sisters' near-immediate response to defend their interests while this case is still at the earliest possible stage, there can be no prejudice to the existing parties. *See, e.g., Smith v. Los Angeles Unified Sch. Dist.*, 830 F.3d 843, 857 (9th Cir. 2016) ("the only 'prejudice' that is relevant under this factor is that which flows from [the] prospective intervenor's" delay) (citation omitted). Rule 24(a)(2)'s timeliness requirement is therefore satisfied.

B. The Little Sisters have a protectable interest in not being forced to choose between violating their faith and paying crippling fines.

The Little Sisters also have a significant protectable interest in this litigation—in fact, theirs is more significant and concrete than that of the plaintiff States. For purposes of Rule 24(a)(2), an "applicant has a significant protectable interest in an action if (1) it asserts an interest that is protected under some law, and (2) there is a relationship between its legally protected interest and the plaintiff's claim." *California ex rel. Lockyer v. United States*, 450 F.3d 436, 441 (9th Cir. 2006) (quoting *Donnelly v. Glickman*, 159 F.3d 405, 409 (9th Cir. 1998)). The quintessential example of a case meeting this criterion is one in which "the injunctive relief sought by the plaintiffs will have direct, immediate, and harmful effects upon [the proposed intervenor's] legally protectable interests." *Berg*, 268 F.3d at 818 (citation omitted).

That is precisely the case here. The federal government candidly admits that the IFR was prompted by the Little Sisters' case and the Supreme Court order they obtained; the IFR is designed to protect them. *See* 82 Fed. Reg. at 47,792-801. The Little Sisters have a direct and immediate interest in the validity of that protection. Yet Plaintiffs' lawsuit

1 seeks to enjoin the IFR. Worse yet, Plaintiffs ask this Court to declare that not only the
2 IFR itself, but any similar exemption arrangement protecting the Little Sisters would
3 violate the Establishment and Equal Protection Clauses. *See* Am. Compl., Dkt. 24 at 30-
4 31 (asking the Court to declare that a full exemption for any groups other than churches
5 is unlawful). This amounts to both an attack on the Supreme Court’s *Zubik* decision and
6 a challenge to any exemption scheme that would fully protect the Little Sisters. The
7 Little Sisters have been in court for more than four years fighting to establish their legal
8 right to just such an exemption. A decision foreclosing the IFR and any similar
9 exemption would have “direct, immediate, and harmful effects upon [the Little Sisters’]
10 legally protectable interests.” *Berg*, 268 F.3d at 818 (citation omitted).

11 This analysis is confirmed by the Ninth Circuit’s *Lockyer* decision. In *Lockyer*, the
12 State of California sued the federal government, challenging the constitutionality of a
13 federal law that “would arguably make California ineligible for certain federal funds” if
14 California enforced its statute requiring healthcare providers to either provide
15 emergency abortions or risk losing their medical licenses. 450 F.3d at 439-40. The Ninth
16 Circuit held that California healthcare providers who objected on religious grounds to
17 providing emergency abortions were entitled to intervene in the federal law’s defense.
18 For the proposed intervenors, the court reasoned, the law “provide[d] an important layer
19 of protection against . . . loss of their medical licenses.” *Id.* at 441. Thus, the court
20 concluded, if California were to succeed in its lawsuit, the proposed intervenors would
21 “be more likely to be forced to choose between adhering to their beliefs and losing their
22 professional licenses”—giving them a protectable interest in the lawsuit under Rule
23 24(a)(2). *Id.*

1 So too here. Like the law at issue in *Lockyer*, both *Zubik* and the IFR “provide[]an
 2 important layer of protection against” the Little Sisters’ incurring massive fines for
 3 adhering to their religious beliefs. *Id.* And as in *Lockyer*, if the States here were to
 4 succeed in their lawsuit, the Little Sisters would “be more likely to be forced to choose
 5 between adhering to their beliefs and” incurring those penalties. *Id.* Indeed, that appears
 6 to be the entire point of Plaintiffs’ lawsuit. Thus, the interest the Little Sisters seek to
 7 protect “is sufficiently ‘direct, non-contingent, and substantial’” for intervention as of
 8 right. *Id.* (quoting *Dilks v. Aloha Airlines, Inc.*, 642 F.2d 1155, 1157 (9th Cir. 1981)).

9 **C. The Little Sisters’ ability to protect their interests may be impaired by**
 10 **the disposition of this action.**

11 Once a court determines that a proposed intervenor “ha[s] a significant protectable
 12 interest,” it should have “little difficulty concluding that the disposition of th[e] case may,
 13 as a practical matter, affect” the intervenor. *Citizens for Balanced Use*, 647 F.3d at 898
 14 (citation omitted). “If an absentee would be substantially affected in a practical sense by
 15 the determination made in an action, he should, as a general rule, be entitled to
 16 intervene.” *Id.* (quoting Fed. R. Civ. P. 24 advisory committee note).

17 Here, if Plaintiffs prevail, the Little Sisters will be affected in the same way as the
 18 intervenors would have been affected in *Lockyer*: they will lose “an important layer of
 19 protection against” being compelled to violate their faith. *Lockyer*, 450 F.3d at 441.
 20 Plaintiffs seek to have the IFR declared unconstitutional and permanently enjoined, and
 21 they seek a declaration that all similar exemptions are unlawful. Dkt. 1 at 18-19, Dkt. 24
 22 at 32. That relief would impair the Little Sisters’ interests by making it “more likely”
 23 that they will “be forced to choose between adhering to their beliefs and” incurring the

1 massive penalties imposed by the Mandate. *Lockyer*, 450 F.3d at 441. Plaintiffs’
2 requested injunction would also directly contradict the Little Sisters’ existing injunctive
3 relief from the Supreme Court. *Cf. Bergh v. State of Wash.*, 535 F.2d 505, 507 (9th Cir.
4 1976) (Kennedy, J.) (“When an injunction sought in one federal proceeding would
5 interfere with another federal proceeding, considerations of comity require more than
6 the usual measure of restraint, and such injunctions should be granted only in the most
7 unusual cases.”).

8 Just as in *Lockyer*, the Little Sisters have no “adequate alternative forum where they
9 can mount a robust defense of the [IFR].” *Lockyer*, 450 F.3d at 442. Plaintiffs seek a
10 nationwide injunction against the IFR and a ruling that would undermine any similar
11 attempts to protect the Little Sisters’ religious exercise. It is necessary for the Little
12 Sisters to intervene here in order to ensure that their previous legal victory is protected.

13 **D. The Little Sisters’ interests are not adequately represented by the**
14 **existing parties to the action.**

15 Finally, intervention should be granted because the Government does not adequately
16 represent the Little Sisters’ interests. The Little Sisters’ “burden of showing inadequacy
17 of representation is minimal and satisfied if the applicant can demonstrate that
18 representation of its interests may be inadequate.” *Citizens for Balanced Use*, 647 F.3d
19 at 898 (quotation omitted). “Any doubt as to whether the existing parties will adequately
20 represent the intervenor should be resolved in favor of intervention.” *In Def. of Animals*
21 *v. U.S. Dep’t of the Interior*, No. 2:10-cv-01852, 2011 WL 1085991 at *3 (E.D. Cal. 2011)
22 (citation omitted).
23

Indeed, the Defendant federal government agencies and the Little Sisters have long been in conflict over these very issues. For the last four years, the federal government has threatened the Little Sisters with massive fines if they continue to engage in their religious exercise. *Little Sisters of the Poor*, 794 F.3d at 1167, *vacated and remanded sub nom. Zubik*, 136 S. Ct. 1557 (noting that “a single Little Sisters home could incur penalties of up to \$2.5 million per year, and allege the Trust could lose up to \$130 million in plan contributions”). And to this day, the federal government Defendants and the Little Sisters remain adverse parties in separate litigation over the same issue. *Little Sisters of the Poor Home for the Aged v. Sebelius*, No. 1:13-cv-02611 (D. Colo. June 17, 2016), Dkt. No. 78 (vacating judgment but not entering any other judgment in the case). That is more than enough to show that HHS’s “representation may be inadequate.” *Citizens for Balanced Use*, 647 F.3d at 898; *Nat’l Ass’n of Home Builders v. San Joaquin Valley Unified Air Pollution Dist.*, 1:07-cv-0820, 2007 WL 2757995 at *5 (E.D. Cal. 2007), *aff’d*, 627 F.3d 730, 731 (9th Cir. 2010), *cert. denied* 565 U.S. 930 (2011) (intervention granted where government’s interest may be “motivated by cost and political pressures”).

The federal government changed its rule because of the Little Sisters’ successful litigation. In such circumstances, the Ninth Circuit has repeatedly recognized that the government does not adequately represent the interests of intervenors. *See, e.g.*:

- *Idaho Farm Bureau Fed’n v. Babbitt*, 58 F.3d 1392, 1398 (9th Cir. 1995) (agency defending a rule did not adequately represent proponents of the rule when agency had refused to make a decision on the rule until after intervenors filed a lawsuit to compel the decision);
- *Citizens for Balanced Use*, 647 F.3d at 900 (government did not adequately

1 represent intervenors because it issued its order “only reluctantly in response to
2 successful litigation by Applicants”);

- 3 • *County of Fresno v. Andrus*, 622 F.2d 436, 439 (9th Cir. 1980) (no adequate
4 representation where “the [government] began its rulemaking only reluctantly
5 after [intervenor] brought a law suit against it”).

6 These facts undermine any “presumption of adequate representation” in the
7 government defending its own regulations, which in any case is not “applied to parties
8 who are antagonists.” *See United States v. City of Los Angeles*, 288 F.3d 391, 401-02 (9th
9 Cir. 2002) (quotation omitted). The federal government cannot be presumed to represent
10 the interests of the Little Sisters when the government’s actions were required by the
11 Little Sisters’ Supreme Court victory on this very subject.

12 The “Government’s representation of the public interest” is not “identical to the
13 [Little Sisters’] parochial interest.” *Citizens for Balanced Use*, 647 F.3d at 899 (quotation
14 omitted). This distinction between the Little Sisters’ particular interest and the federal
15 government’s broad interest is alone enough to justify intervention. In cases challenging
16 government action, “[i]nadequate representation is most likely to be found when the
17 applicant asserts a personal interest that does not belong to the general public.” *Forest
18 Conservation Council v. U.S. Forest Serv.*, 66 F.3d 1489, 1499 (9th Cir. 1995), *abrogated
19 on other grounds by Wilderness Soc’y v. Forest Serv.*, 630 F.3d 1173 (9th Cir. 2011). This
20 is because the government has the broader responsibility of representing the public
21 interest and the government’s policy views in general, which may not align with those of
22 the individual right holder. *See, e.g., Cal. Dump Truck Owners Ass’n v. Nichols*, 275
23 F.R.D. 303, 308 (E.D. Cal. 2011) (private applicant not adequately represented by

1 government agency because applicant's interests were more "narrow and parochial" and
2 agency was required to consider "impact its rules will have on the state as a whole");
3 *Delano Farms Co. v. Cal. Table Grape Comm'n*, 1:07-CV-1610, 2010 WL 2942754, at *2
4 (E.D. Cal. 2010) (no adequacy of representation because "USDA, as an agency of the
5 Executive Branch must balance a number of policy considerations"); *Associated Gen.*
6 *Contractors of Am. v. Cal. Dep't of Transp.*, No. 09-01622, 2009 WL 5206722, at *3 (E.D.
7 Cal. 2009) (representation inadequate where applicant had "a personal stake in the
8 program and in the outcome of this lawsuit" and agency's main charge was promoting
9 the public interest). Thus, applicants are not adequately represented by a government
10 agency if the agency's interest is "not simply to confirm" the applicant's interest, but
11 includes a broader "range of considerations." *Berg*, 268 F.3d at 823.

12 Here, the federal government's interest is not "simply to confirm" the Little Sisters'
13 interest in avoiding massive fines for their religious exercise. Rather, the federal
14 government is expressly "balanc[ing]" the Little Sisters' interest against "the
15 Government's interest in ensuring coverage for contraceptive and sterilization services."
16 82 Fed. Reg. at 47,793. The federal government is also considering its broader interests
17 in public health, implementation of the Affordable Care Act, the cost of its regulations,
18 and the potential impact on other federal government programs. *Id.* at 47,803
19 (considering the impact on other programs), 47,821 (considering the cost of the
20 exemption). Given the federal agency Defendants' other considerations there is no
21 possibility that they "will undoubtedly make all the intervenor's arguments," as the
22 standard requires. *Berg*, 268 F.3d at 822 (quoting *Nw. Forest Res. Council v. Glickman*,
23 82 F.3d 825, 838 (9th Cir. 1996)).

1 **II. Alternatively, the Little Sisters should be permitted to intervene under**
2 **Rule 24(b).**

3 Were the Court to deny intervention as of right, it should nevertheless grant
4 permissive intervention under Rule 24(b). Rule 24(b) authorizes this Court to “permit
5 anyone to intervene” who “has a claim or defense that shares with the main action a
6 common question of law or fact,” as long as the intervenor has “an independent ground
7 for jurisdiction” and has made a “a timely motion.” Fed. R. Civ. P. 24(b); *Beckman Indus.,*
8 *Inc.*, 966 F.2d at 473.

9 The Little Sisters’ interest in protecting the IFR presents common questions of law
10 and fact with those of the existing parties. As noted above, this motion is timely and
11 intervention at this early stage will not prejudice the current parties. The significance of
12 the Little Sisters’ interests in the subject matter of this litigation outweighs any
13 marginal additional burden that would be caused by intervention. *See City of Los*
14 *Angeles*, 288 F.3d at 404 (reversing denial of permissive intervention, noting that
15 “‘streamlining’ the litigation . . . should not be accomplished at the risk of marginalizing
16 those . . . who have some of the strongest interests in the outcome”). Additionally all the
17 factors discussed above that support intervention as a matter of right also support
18 permissive intervention. *See, e.g., Venegas v. Skaggs*, 867 F.2d 527, 530 (9th Cir. 1989),
19 *aff’d sub nom. Venegas v. Mitchell*, 495 U.S. 82 (1990). Thus, even if the Court concluded
20 that the Little Sisters cannot intervene as of right, it should nonetheless permit
21 intervention under Fed. R. Civ. P. 24(b).

22 **CONCLUSION**

23 For the foregoing reasons, the Little Sisters’ motion to intervene should be granted.

1 Dated: November 21, 2017

Respectfully submitted,

2
3 /s/ Eric C. Rassbach

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

THE STATE OF CALIFORNIA; THE
STATE OF DELAWARE; THE STATE OF
MARYLAND; THE STATE OF NEW YORK;
THE COMMONWEALTH OF VIRGINIA,

Plaintiffs,

v.

ERIC D. HARGAN, in his official capacity as
Acting Secretary of the U.S. Department of
Health and Human Services; U.S.
DEPARTMENT OF HEALTH AND
HUMAN SERVICES; R. ALEXANDER
ACOSTA, in his official capacity as
Secretary of U.S. Department of Labor; U.S.
DEPARTMENT OF LABOR; STEVEN
MNUCHIN, in his official capacity as
Secretary of the U.S. Department of the
Treasury; U.S. DEPARTMENT OF THE
TREASURY; DOES 1-100,

Defendants,

and,

THE LITTLE SISTERS OF THE POOR,
JEANNE JUGAN RESIDENCE,

Defendant-Intervenor.

Case No. 4:17-cv-05783-HSG

**[PROPOSED] ORDER
GRANTING MOTION TO
INTERVENE**

ORDER

Pending before the Court is the Motion to Intervene of proposed Defendant-Intervenor The Little Sisters of the Poor, Jeanne Jugan Residence. After due consideration, this Court GRANTS the motion to intervene.

SIGNED this ____ day of _____, 20____.

HAYWOOD S. GILLIAM, JR.
U.S. District Judge

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**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA**

THE STATE OF CALIFORNIA; THE
STATE OF DELAWARE; THE STATE
OF MARYLAND; THE STATE OF
NEW YORK; THE
COMMONWEALTH OF VIRGINIA,

Plaintiffs,

v.

ERIC D. HARGAN, in his official
capacity as Acting Secretary of the
U.S. Department of Health and
Human Services; U.S. DEPARTMENT
OF HEALTH AND HUMAN
SERVICES; R. ALEXANDER
ACOSTA, in his official capacity as
Secretary of U.S. Department of Labor;
U.S. DEPARTMENT OF LABOR;
STEVEN MNUCHIN, in his official
capacity as Secretary of the U.S.
Department of the Treasury; U.S.
DEPARTMENT OF THE TREASURY;
DOES 1-100,

Defendants,

and,

THE LITTLE SISTERS OF THE
POOR JEANNE JUGAN
RESIDENCE,

Defendant-Intervenor.

Case No. 4:17-cv-05783-HSG

**PROPOSED ANSWER OF
PROPOSED DEFENDANT-
INTERVENOR LITTLE SISTERS
OF THE POOR JEANNE JUGAN
RESIDENCE**

1 Defendant-Intervenor Little Sisters of Poor Jeanne Jugan Residence (hereafter,
2 “Intervenor”) submits this proposed answer to Plaintiffs’ First Amended Complaint.
3 Intervenor denies all allegations not expressly admitted or qualified herein.

4 1. Paragraph 1 of the Complaint contains legal conclusions and characterizations
5 as to which no response is required. Intervenor admits the allegation in Paragraph 1 of
6 the Complaint that contraceptives and other birth-control services are widely available
7 and widely used in the United States. Intervenor otherwise lacks knowledge or
8 information sufficient to form a belief about the truth of the allegations set forth in
9 Paragraph 1 of the Complaint and therefore denies the same.
10

11 2. Paragraph 2 of the Complaint contains legal conclusions, speculation, and
12 Plaintiffs’ characterizations of the Interim Final Rules (“IFRs”), the regulations
13 requiring the certain employers’ group health plans provide contraception, sterilization,
14 and abortion-inducing drugs (“HHS Mandate”), and the accommodation scheme
15 (“Accommodation”) adopted by the previous administration to purportedly accommodate
16 religious objectors to the HHS Mandate. None of these legal conclusions and
17 characterizations require a response. Further, Intervenor denies that these conclusions
18 and characterizations provide an accurate statement of the law.
19

20 3. Intervenor admits that Paragraph 3 correctly identifies the Plaintiffs to this case
21 who are challenging the IFRs. Paragraph 3 otherwise contains legal conclusions to which
22 no response is required; further, Intervenor denies that this is an accurate statement of
23 the law. Intervenor denies that Plaintiffs have suffered or will suffer any cognizable
24 injury as result of the IFRs.
25

1 4. Paragraph 4 contains legal conclusions to which no response is required.

2 5. Paragraph 5 contains legal conclusions to which no response is required.

3 6. Paragraph 6 contains legal conclusions to which no response is required.

4 7. Paragraph 7 contains legal conclusions to which no response is required.

5 8. Intervenor admits that California is a plaintiff to this action and is represented
6 by its attorney general. The remainder of Paragraph 8 contains legal conclusions to
7 which no response is required.
8

9 9. Intervenor admits that Delaware is a plaintiff to this action and is represented
10 by its attorney general. The remainder of Paragraph 9 contains legal conclusions to
11 which no response is required.

12 10. Intervenor admits that Maryland is a plaintiff to this action and is represented
13 by its attorney general. The remainder of Paragraph 10 contains legal conclusions to
14 which no response is required.

15 11. Intervenor admits that New York is a plaintiff to this action and is represented
16 by its attorney general. The remainder of Paragraph 11 contains legal conclusions to
17 which no response is required.
18

19 12. Intervenor admits that Virginia is a plaintiff to this action and is represented by
20 its attorney general. The remainder of Paragraph 12 contains legal conclusions to which
21 no response is required.

22 13. Paragraph 13 contains legal conclusions to which no response is required;
23 further, Intervenor denies that this is an accurate statement of the law.
24
25
26

1 14. Paragraph 14 contains legal conclusions to which no response is required;
2 further, Intervenor denies that this is an accurate statement of the law. Intervenor
3 denies that Plaintiffs have suffered or will suffer any cognizable injury as result of the
4 IFRs.

5 15. Paragraph 15 contains legal conclusions to which no response is required;
6 further, Intervenor denies that this is an accurate statement of the law. Intervenor
7 denies that Plaintiffs have suffered or will suffer any cognizable injury as result of the
8 IFRs.

9 16. Paragraph 16 otherwise contains legal conclusions to which no response is
10 required; further, Intervenor denies that this is an accurate statement of the law.
11 Intervenor denies that Plaintiffs have suffered or will suffer any cognizable injury as
12 result of the IFRs.

13 17. Intervenor admits the allegations in Paragraph 17.

14 18. Intervenor admits the allegations in Paragraph 18.

15 19. Intervenor admits the allegations in Paragraph 19.

16 20. Intervenor admits the allegations in Paragraph 20.

17 21. Intervenor admits the allegations in Paragraph 21.

18 22. Intervenor admits the allegations in Paragraph 22.

19 23. Paragraph 23 contains legal conclusions and characterizations to which no
20 response is required; to the extent that the text of the Affordable Care Act (“ACA”), is
21 cited, the law speaks for itself.

22 24. Intervenor denies the allegations in Paragraph 24.

1 25. Intervenor admits the allegation in Paragraph 25 that the Institute of Medicine
2 (“IOM”) issued a report on recommended preventative care for women. Intervenor denies
3 that the IOM report “recommended that private insurance plans be required to cover all
4 contraceptive benefits and services.” IOM was not tasked with making insurance
5 coverage recommendations, and explicitly excluded from its determinations
6 considerations, including those regarding cost, that would be relevant to insurance
7 coverage recommendations.
8

9 26. Paragraph 26 contains characterizations of the IOM report to which no response
10 is required; the report speaks for itself.

11 27. Paragraph 27 contains characterizations of the IOM report to which no response
12 is required; the report speaks for itself.

13 28. Intervenor admits the allegations in Paragraph 28.

14 29. Paragraph 29 contains legal conclusions to which no response is required.

15 30. Paragraph 30 contains legal conclusions to which no response is required.

16 31. Paragraph 31 contains legal conclusions to which no response is required. To the
17 extent Paragraph 31 is characterizing the Guidelines promulgated by the Health
18 Resources and Services Administration (“HRSA”), the Guidelines speak for themselves.
19

20 32. Paragraph 32 contains legal conclusions to which no response is required. To the
21 extent Paragraph 32 is characterizing reports by HRSA and other entities, those reports
22 speak for themselves.

23 33. Paragraph 33 contains legal conclusions to which no response is required; the
24 cited statute speaks for itself.
25
26

1 34. Paragraph 34 contains legal conclusions to which no response is required; the
2 Administrative Procedures Act (“APA”) speaks for itself.

3 35. Intervenor lacks knowledge or information sufficient to form a belief about the
4 truth of the allegations set forth in Paragraph 35 of the Complaint and therefore denies
5 the same. Intervenor admits that contraceptives are widely available and widely used in
6 the United States.

7
8 36. Intervenor lacks knowledge or information sufficient to form a belief about the
9 truth of the allegations set forth in Paragraph 36 of the Complaint and therefore denies
10 the same.

11 37. Intervenor lacks knowledge or information sufficient to form a belief about the
12 truth of the allegations set forth in Paragraph 37 of the Complaint and therefore denies
13 the same.

14 38. Intervenor lacks knowledge or information sufficient to form a belief about the
15 truth of the allegations set forth in Paragraph 38 of the Complaint and therefore denies
16 the same. Intervenor admits that some contraceptives can be prescribed for reasons
17 unrelated to preventing or ending a pregnancy, and Intervenor has no religious objection
18 to such non-pregnancy-related prescriptions.

19
20 39. Intervenor lacks knowledge or information sufficient to form a belief about the
21 truth of the allegations set forth in Paragraph 39 of the Complaint and therefore denies
22 the same.

1 40. Intervenor lacks knowledge or information sufficient to form a belief about the
2 truth of the allegations set forth in Paragraph 40 of the Complaint and therefore denies
3 the same.

4 41. Intervenor lacks knowledge or information sufficient to form a belief about the
5 truth of the allegations set forth in Paragraph 41 of the Complaint and therefore denies
6 the same.

7 42. Intervenor lacks knowledge or information sufficient to form a belief about the
8 truth of the allegations set forth in Paragraph 42 of the Complaint and therefore denies
9 the same. Intervenor denies that Plaintiffs have suffered or will suffer any cognizable
10 injury as result of the IFRs.

11 43. Intervenor lacks knowledge or information sufficient to form a belief about the
12 truth of the allegations set forth in Paragraph 43 of the Complaint and therefore denies
13 the same.

14 44. Intervenor lacks knowledge or information sufficient to form a belief about the
15 truth of the allegations set forth in Paragraph 44 of the Complaint and therefore denies
16 the same. Further, Paragraph 44 contains legal conclusions to which no response is
17 required.

18 45. Intervenor lacks knowledge or information sufficient to form a belief about the
19 truth of the allegations set forth in Paragraph 45 of the Complaint and therefore denies
20 the same. Further, Paragraph 45 contains legal conclusions to which no response is
21 required.

1 46. Intervenor lacks knowledge or information sufficient to form a belief about the
2 truth of the allegations set forth in Paragraph 46 of the Complaint and therefore denies
3 the same. Further, Paragraph 46 contains legal conclusions to which no response is
4 required.

5 47. Intervenor lacks knowledge or information sufficient to form a belief about the
6 truth of the speculative allegations set forth in Paragraph 47 of the Complaint and
7 therefore denies the same. Further, Paragraph 47 contains legal conclusions to which no
8 response is required. Intervenor denies that California has suffered or will suffer any
9 cognizable injury as result of the IFRs.
10

11 48. Intervenor lacks knowledge or information sufficient to form a belief about the
12 truth of the speculative allegations set forth in Paragraph 48 of the Complaint and
13 therefore denies the same. Further, Paragraph 48 contains legal conclusions to which no
14 response is required. Intervenor denies that California has suffered or will suffer any
15 cognizable injury as result of the IFRs.
16

17 49. Intervenor lacks knowledge or information sufficient to form a belief about the
18 truth of the allegations set forth in Paragraph 49 of the Complaint and therefore denies
19 the same. Further, Paragraph 49 contains legal conclusions to which no response is
20 required.

21 50. Intervenor lacks knowledge or information sufficient to form a belief about the
22 truth of the allegations set forth in Paragraph 50 of the Complaint and therefore denies
23 the same. Further, Paragraph 50 contains legal conclusions to which no response is
24 required.
25

1 51. Intervenor lacks knowledge or information sufficient to form a belief about the
2 truth of the allegations set forth in Paragraph 51 of the Complaint and therefore denies
3 the same. Further, Paragraph 51 contains legal conclusions to which no response is
4 required.

5 52. Intervenor lacks knowledge or information sufficient to form a belief about the
6 truth of the speculative allegations set forth in Paragraph 52 of the Complaint and
7 therefore denies the same. Further, Paragraph 52 contains legal conclusions to which no
8 response is required. Intervenor denies that California has suffered or will suffer any
9 cognizable injury as result of the IFRs.
10

11 53. Intervenor lacks knowledge or information sufficient to form a belief about the
12 truth of the speculative allegations set forth in Paragraph 53 of the Complaint and
13 therefore denies the same. Further, Paragraph 53 contains legal conclusions to which no
14 response is required. Intervenor denies that Delaware has suffered or will suffer any
15 cognizable injury as result of the IFRs.
16

17 54. Intervenor lacks knowledge or information sufficient to form a belief about the
18 truth of the allegations set forth in Paragraph 54 of the Complaint and therefore denies
19 the same. Further, Paragraph 54 contains legal conclusions to which no response is
20 required.

21 55. Intervenor lacks knowledge or information sufficient to form a belief about the
22 truth of the allegations set forth in Paragraph 55 of the Complaint and therefore denies
23 the same. Further, Paragraph 55 contains legal conclusions to which no response is
24 required.
25

1 56. Intervenor lacks knowledge or information sufficient to form a belief about the
2 truth of the allegations set forth in Paragraph 56 of the Complaint and therefore denies
3 the same. Further, Paragraph 56 contains legal conclusions to which no response is
4 required.

5 57. Intervenor lacks knowledge or information sufficient to form a belief about the
6 truth of the speculative allegations set forth in Paragraph 57 of the Complaint and
7 therefore denies the same. Further, Paragraph 57 contains legal conclusions to which no
8 response is required. Intervenor denies that Delaware has suffered or will suffer any
9 cognizable injury as result of the IFRs.
10

11 58. Intervenor lacks knowledge or information sufficient to form a belief about the
12 truth of the allegations set forth in Paragraph 58 of the Complaint. Further, Paragraph
13 58 contains legal conclusions to which no response is required; the cited statute speaks
14 for itself.

15 59. Intervenor lacks knowledge or information sufficient to form a belief about the
16 truth of the allegations set forth in Paragraph 59 of the Complaint and therefore denies
17 the same. Further, Paragraph 59 contains legal conclusions to which no response is
18 required.
19

20 60. Intervenor lacks knowledge or information sufficient to form a belief about the
21 truth of the allegations set forth in Paragraph 60 of the Complaint and therefore denies
22 the same.

23 61. Intervenor lacks knowledge or information sufficient to form a belief about the
24 truth of the allegations set forth in Paragraph 61 of the Complaint and therefore denies
25

1 the same. Further, Paragraph 61 contains legal conclusions to which no response is
2 required.

3 62. Intervenor lacks knowledge or information sufficient to form a belief about the
4 truth of the speculative allegations set forth in Paragraph 62 of the Complaint and
5 therefore denies the same. Further, Paragraph 62 contains legal conclusions to which no
6 response is required. Intervenor denies that Delaware has suffered or will suffer any
7 cognizable injury as result of the IFRs.
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9 63. Intervenor lacks knowledge or information sufficient to form a belief about the
10 truth of the allegations set forth in Paragraph 63 of the Complaint and therefore denies
11 the same.

12 64. Intervenor lacks knowledge or information sufficient to form a belief about the
13 truth of the allegations set forth in Paragraph 64 of the Complaint and therefore denies
14 the same. Further, Paragraph 64 contains legal conclusions to which no response is
15 required.
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17 65. Intervenor lacks knowledge or information sufficient to form a belief about the
18 truth of the allegations set forth in Paragraph 65 of the Complaint and therefore denies
19 the same. Further, Paragraph 65 contains legal conclusions to which no response is
20 required.
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22 66. Intervenor lacks knowledge or information sufficient to form a belief about the
23 truth of the speculative allegations set forth in Paragraph 66 of the Complaint and
24 therefore denies the same. Further, Paragraph 66 contains legal conclusions to which no
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1 response is required. Intervenor denies that Maryland has suffered or will suffer any
2 cognizable injury as result of the IFRs.

3 67. Intervenor lacks knowledge or information sufficient to form a belief about the
4 truth of the speculative allegations set forth in Paragraph 67 of the Complaint and
5 therefore denies the same. Further, Paragraph 67 contains legal conclusions to which no
6 response is required. Intervenor denies that Maryland has suffered or will suffer any
7 cognizable injury as result of the IFRs.
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9 68. Intervenor lacks knowledge or information sufficient to form a belief about the
10 truth of the speculative allegations set forth in Paragraph 68 of the Complaint and
11 therefore denies the same. Further, Paragraph 68 contains legal conclusions to which no
12 response is required. Intervenor denies that Maryland has suffered or will suffer any
13 cognizable injury as result of the IFRs.

14 69. Intervenor lacks knowledge or information sufficient to form a belief about the
15 truth of the speculative allegations set forth in Paragraph 69 of the Complaint and
16 therefore denies the same. Further, Paragraph 69 contains legal conclusions to which no
17 response is required. Intervenor denies that Maryland has suffered or will suffer any
18 cognizable injury as result of the IFRs.
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20 70. Intervenor lacks knowledge or information sufficient to form a belief about the
21 truth of the speculative allegations set forth in Paragraph 70 of the Complaint and
22 therefore denies the same.

23 71. Intervenor lacks knowledge or information sufficient to form a belief about the
24 truth of the speculative allegations set forth in Paragraph 71 of the Complaint and
25

1 therefore denies the same. Further, Paragraph 71 contains legal conclusions to which no
2 response is required. Intervenor denies that Maryland has suffered or will suffer any
3 cognizable injury as result of the IFRs.

4 72. Intervenor lacks knowledge or information sufficient to form a belief about the
5 truth of the allegations set forth in Paragraph 72 of the Complaint and therefore denies
6 the same.

7 73. Intervenor lacks knowledge or information sufficient to form a belief about the
8 truth of the speculative allegations set forth in Paragraph 73 of the Complaint and
9 therefore denies the same. Further, Paragraph 73 contains legal conclusions to which no
10 response is required.

11 74. Intervenor lacks knowledge or information sufficient to form a belief about the
12 truth of the allegations set forth in Paragraph 74 of the Complaint and therefore denies
13 the same. Further, Paragraph 74 contains legal conclusions to which no response is
14 required.

15 75. Intervenor lacks knowledge or information sufficient to form a belief about the
16 truth of the allegations set forth in Paragraph 75 of the Complaint and therefore denies
17 the same. Further, Paragraph 75 contains legal conclusions to which no response is
18 required.

19 76. Intervenor lacks knowledge or information sufficient to form a belief about the
20 truth of the allegations set forth in Paragraph 76 of the Complaint and therefore denies
21 the same. Further, Paragraph 76 contains legal conclusions to which no response is
22 required.

1 77. Intervenor lacks knowledge or information sufficient to form a belief about the
2 truth of the allegations set forth in Paragraph 77 of the Complaint and therefore denies
3 the same. Further, Paragraph 77 contains legal conclusions to which no response is
4 required.

5 78. Intervenor lacks knowledge or information sufficient to form a belief about the
6 truth of the allegations set forth in Paragraph 78 of the Complaint and therefore denies
7 the same. Further, Paragraph 78 contains legal conclusions to which no response is
8 required.
9

10 79. Intervenor lacks knowledge or information sufficient to form a belief about the
11 truth of the speculative allegations set forth in Paragraph 79 of the Complaint and
12 therefore denies the same. Further, Paragraph 79 contains legal conclusions to which no
13 response is required.

14 80. Intervenor lacks knowledge or information sufficient to form a belief about the
15 truth of the allegations set forth in Paragraph 80 of the Complaint and therefore denies
16 the same. Further, Paragraph 80 contains legal conclusions to which no response is
17 required.
18

19 81. Intervenor lacks knowledge or information sufficient to form a belief about the
20 truth of the speculative allegations set forth in Paragraph 81 of the Complaint and
21 therefore denies the same. Further, Paragraph 81 of the Complaint contains legal
22 conclusions as to which no response is required. Intervenor denies that New York has
23 suffered or will suffer any cognizable injury as result of the IFRs.
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1 82. Intervenor lacks knowledge or information sufficient to form a belief about the
2 truth of the speculative allegations set forth in Paragraph 82 of the Complaint and
3 therefore denies the same. Further, Paragraph 82 of the Complaint contains legal
4 conclusions as to which no response is required. Intervenor denies that New York has
5 suffered or will suffer any cognizable injury as result of the IFRs.

6 83. Intervenor lacks knowledge or information sufficient to form a belief about the
7 truth of the speculative allegations set forth in Paragraph 83 of the Complaint and
8 therefore denies the same. Intervenor denies that New York has suffered or will suffer
9 any cognizable injury as result of the IFRs.

10 84. Intervenor lacks knowledge or information sufficient to form a belief about the
11 truth of the speculative allegations set forth in Paragraph 84 of the Complaint and
12 therefore denies the same. Intervenor denies that New York has suffered or will suffer
13 any cognizable injury as result of the IFRs.

14 85. Intervenor lacks knowledge or information sufficient to form a belief about the
15 truth of the allegations set forth in Paragraph 85 of the Complaint and therefore denies
16 the same.

17 86. Intervenor lacks knowledge or information sufficient to form a belief about the
18 truth of the speculative allegations set forth in Paragraph 86 of the Complaint and
19 therefore denies the same. Further, Paragraph 86 contains legal conclusions to which no
20 response is required. Intervenor denies that Virginia has suffered or will suffer any
21 cognizable injury as result of the IFRs.

1 87. Intervenor lacks knowledge or information sufficient to form a belief about the
2 truth of the allegations set forth in Paragraph 87 of the Complaint and therefore denies
3 the same.

4 88. Intervenor lacks knowledge or information sufficient to form a belief about the
5 truth of the allegations set forth in Paragraph 88 of the Complaint and therefore denies
6 the same. Further, Paragraph 88 contains legal conclusions to which no response is
7 required.

8 89. Intervenor lacks knowledge or information sufficient to form a belief about the
9 truth of the allegations set forth in Paragraph 89 of the Complaint and therefore denies
10 the same. Further, Paragraph 89 contains legal conclusions to which no response is
11 required.

12 90. Intervenor lacks knowledge or information sufficient to form a belief about the
13 truth of the allegations set forth in Paragraph 90 of the Complaint and therefore denies
14 the same. Further, Paragraph 90 contains legal conclusions to which no response is
15 required.

16 91. Intervenor lacks knowledge or information sufficient to form a belief about the
17 truth of the allegations set forth in Paragraph 91 of the Complaint and therefore denies
18 the same. Further, Paragraph 91 contains legal conclusions to which no response is
19 required.

20 92. Intervenor lacks knowledge or information sufficient to form a belief about the
21 truth of the speculative allegations set forth in Paragraph 92 of the Complaint and
22 therefore denies the same. Further, Paragraph 92 contains legal conclusions to which no
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1 response is required. Intervenor denies that Virginia has suffered or will suffer any
2 cognizable injury as result of the IFRs.

3 93. Intervenor lacks knowledge or information sufficient to form a belief about the
4 truth of the speculative allegations set forth in Paragraph 93 of the Complaint and
5 therefore denies the same. Further, Paragraph 93 contains legal conclusions to which no
6 response is required. Intervenor denies that Virginia has suffered or will suffer any
7 cognizable injury as result of the IFRs.
8

9 94. Intervenor lacks knowledge or information sufficient to form a belief about the
10 truth of the allegations set forth in Paragraph 94 of the Complaint and therefore denies
11 the same.

12 95. Paragraph 95 contains legal conclusions to which no response is required;
13 further, Intervenor denies that this is an accurate statement of the law.

14 96. Paragraph 96 contains legal conclusions to which no response is required;
15 further, Intervenor denies that this is an accurate statement of the law.
16

17 97. Paragraph 97 contains legal conclusions to which no response is required;
18 further, Intervenor denies that this is an accurate statement of the law.

19 98. Paragraph 98 contains legal conclusions to which no response is required;
20 further, Intervenor denies that this is an accurate statement of the law.

21 99. Paragraph 99 contains legal conclusions to which no response is required;
22 further, Intervenor denies that this is an accurate statement of the law.
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1 100. Intervenor lacks knowledge or information sufficient to form a belief about the
2 truth of the allegations set forth in Paragraph 100 of the Complaint and therefore denies
3 the same.

4 101. Paragraph 101 contains legal conclusions to which no response is required;
5 further, Intervenor denies that this is an accurate statement of the law. Intervenor
6 admits that the IFRs expanded the original exemption from the HHS Mandate to include
7 religious objectors to the Mandate like the Intervenor.
8

9 102. Paragraph 102 contains legal conclusions to which no response is required;
10 further, Intervenor denies that this is an accurate statement of the law.

11 103. Paragraph 103 contains legal conclusions to which no response is required;
12 further, Intervenor denies that this is an accurate statement of the law.

13 104. Paragraph 104 contains legal conclusions to which no response is required;
14 further, Intervenor denies that this is an accurate statement of the law. Intervenor
15 denies that Plaintiffs have suffered or will suffer any cognizable injury as result of the
16 IFRs.
17

18 105. Paragraph 105 contains legal conclusions to which no response is required;
19 further, Intervenor denies that this is an accurate statement of the law. Intervenor
20 denies that the Plaintiff States have suffered or will suffer any cognizable injury as result
21 of the IFRs.

22 106. Paragraph 106 contains legal conclusions to which no response is required;
23 further, Intervenor denies that this is an accurate statement of the law. Intervenor lacks
24 knowledge or information sufficient to form a belief about the truth of the speculative
25

1 allegations set forth in Paragraph 106 of the Complaint and therefore denies the same.
2 Intervenor denies that California has or will suffer any cognizable injury as result of the
3 IFRs.

4 107. Paragraph 107 contains legal conclusions to which no response is required;
5 further, Intervenor denies that this is an accurate statement of the law. Intervenor lacks
6 knowledge or information sufficient to form a belief about the truth of the speculative
7 allegations set forth in Paragraph 107 of the Complaint and therefore denies the same.
8 Intervenor denies that California has suffered or will suffer any cognizable injury as
9 result of the IFRs.
10

11 108. Paragraph 108 contains legal conclusions to which no response is required;
12 further, Intervenor denies that this is an accurate statement of the law. Intervenor lacks
13 knowledge or information sufficient to form a belief about the truth of the speculative
14 allegations set forth in Paragraph 108 of the Complaint and therefore denies the same.
15 Intervenor denies that Maryland has suffered or will suffer any cognizable injury as
16 result of the IFRs.
17

18 109. Paragraph 109 contains legal conclusions to which no response is required;
19 further, Intervenor denies that this is an accurate statement of the law. Intervenor lacks
20 knowledge or information sufficient to form a belief about the truth of the speculative
21 allegations set forth in Paragraph 109 of the Complaint and therefore denies the same.
22 Intervenor denies that New York has suffered or will suffer any cognizable injury as
23 result of the IFRs.
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1 110. Intervenor lacks knowledge or information sufficient to form a belief about the
2 truth of the speculative allegations set forth in Paragraph 110 of the Complaint and
3 therefore denies the same.

4 111. Intervenor lacks knowledge or information sufficient to form a belief about the
5 truth of the speculative allegations set forth in Paragraph 111 of the Complaint and
6 therefore denies the same.

7
8 112. Paragraph 112 contains legal conclusions to which no response is required;
9 further, Intervenor denies that this is an accurate statement of the law. Intervenor lacks
10 knowledge or information sufficient to form a belief about the truth of the speculative
11 allegations set forth in Paragraph 112 of the Complaint and therefore denies the same.
12 Intervenor denies that New York has suffered or will suffer any cognizable injury as
13 result of the IFRs.

14 113. Paragraph 113 contains legal conclusions to which no response is required;
15 further, Intervenor denies that this is an accurate statement of the law. Intervenor lacks
16 knowledge or information sufficient to form a belief about the truth of the speculative
17 allegations set forth in Paragraph 113 of the Complaint and therefore denies the same.
18 Intervenor denies that Virginia has suffered or will suffer any cognizable injury as result
19 of the IFRs.
20

21 114. Intervenor lacks knowledge or information sufficient to form a belief about the
22 truth of the speculative allegations set forth in Paragraph 114 of the Complaint and
23 therefore denies the same. Intervenor denies that Plaintiffs have suffered or will suffer
24 any cognizable injury as result of the IFRs.
25

1 115. Paragraph 115 contains legal conclusions to which no response is required;
2 further, Intervenor denies that this is an accurate statement of the law. Intervenor
3 denies that Plaintiffs have suffered or will suffer any cognizable injury as result of the
4 IFRs.

5 116. Paragraph 116 characterizes Plaintiffs' own complaint, which requires no
6 response. Intervenor incorporates by reference all preceding responses.

7 117. Paragraph 117 contains legal conclusions to which no response is required; the
8 APA speaks for itself.

9 118. Paragraph 118 contains legal conclusions to which no response is required; the
10 APA speaks for itself.

11 119. Paragraph 119 contains legal conclusions to which no response is required;
12 further, Intervenor denies that this is an accurate statement of the law.

13 120. Paragraph 120 contains legal conclusions to which no response is required;
14 further, Intervenor denies that this is an accurate statement of the law.

15 121. Paragraph 121 contains legal conclusions to which no response is required; the
16 further, Intervenor denies that this is an accurate statement of the law.

17 122. Paragraph 122 characterizes Plaintiffs' own complaint, which requires no
18 response. Intervenor incorporates by reference all preceding responses.

19 123. Paragraph 123 contains legal conclusions to which no response is required; the
20 APA speaks for itself.

21 124. Paragraph 124 contains legal conclusions to which no response is required;
22 further, Intervenor denies that this is an accurate statement of the law. Intervenor
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1 denies that Plaintiffs have suffered or will suffer any cognizable injury as result of the
2 IFRs.

3 125. Paragraph 125 characterizes Plaintiffs' own complaint, which requires no
4 response. Intervenor incorporates by reference all preceding responses.

5 126. Paragraph 126 contains legal conclusions to which no response is required; the
6 First Amendment's Establishment Clause speaks for itself.

7 127. Paragraph 127 contains legal conclusions to which no response is required;
8 further, Intervenor denies that this is an accurate statement of the law.

9 128. Paragraph 128 contains legal conclusions to which no response is required;
10 further, Intervenor denies that this is an accurate statement of the law.

11 129. Paragraph 129 contains legal conclusions to which no response is required;
12 further, Intervenor denies that this is an accurate statement of the law.

13 130. Paragraph 130 contains legal conclusions to which no response is required;
14 further, Intervenor denies that this is an accurate statement of the law.

15 131. Paragraph 131 contains legal conclusions to which no response is required;
16 further, Intervenor denies that this is an accurate statement of the law. Intervenor
17 denies that Plaintiffs have suffered or will suffer any cognizable injury as result of the
18 IFRs.

19 132. Paragraph 132 characterizes Plaintiffs' own complaint, which requires no
20 response. Intervenor incorporates by reference all preceding responses.

21 133. Paragraph 133 contains legal conclusions to which no response is required; the
22 Fifth Amendment speaks for itself.

1 134. Paragraph 134 contains legal conclusions to which no response is required;
2 further, Intervenor denies that this is an accurate statement of the law.

3 135. Paragraph 135 contains legal conclusions to which no response is required;
4 further, Intervenor denies that this is an accurate statement of the law.

5 136. Paragraph 136 contains legal conclusions to which no response is required;
6 further, Intervenor denies that this is an accurate statement of the law.

7 137. Paragraph 137 contains legal conclusions to which no response is required;
8 further, Intervenor denies that this is an accurate statement of the law. Intervenor
9 denies that Plaintiffs have suffered or will suffer any cognizable injury as result of the
10 IFRs.
11

12 In response to Plaintiffs' prayer for relief, Intervenor denies that Plaintiffs are
13 entitled to any relief whatsoever.
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AFFIRMATIVE DEFENSES

Plaintiffs' request for relief must be denied because:

1. Plaintiffs' requested relief violates the rights secured to Intervenor by the Religious Freedom Restoration Act, 42 U.S.C. § 2000bb et seq.

2. Plaintiffs' requested relief violates the rights secured to Intervenor by the Free Exercise Clause of the First Amendment to the United States Constitution.

3. Plaintiffs' requested relief violates the rights secured to Intervenor by the Establishment Clause of the First Amendment to the United States Constitution.

4. Plaintiffs' requested relief violates the rights secured to Intervenor by the Free Speech Clause of the First Amendment to the United States Constitution.

5. Plaintiffs' requested relief violates the rights secured to Intervenor by the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution.

6. Plaintiffs' requested relief violates the rights secured to Intervenor by existing injunctions from the United States Supreme Court.

7. Plaintiffs' efforts to take away religious exemptions from the contraceptive mandate, after years of making no effort to take away much larger secular exemptions to the mandate, constitutes illegal religious discrimination and religious targeting in violation of the Free Exercise Clause and the religious freedom provisions of Plaintiffs' state constitutions.

1 Dated: November 21, 2017

Respectfully submitted,

2
3 /s/ Eric C. Rassbach

Eric C. Rassbach

The Becket Fund for Religious Liberty

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7 *Counsel for Proposed Defendant-Intervenor*

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**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA**

THE STATE OF CALIFORNIA; THE
STATE OF DELAWARE; THE STATE OF
MARYLAND; THE STATE OF NEW
YORK; THE COMMONWEALTH OF
VIRGINIA,

Plaintiffs,

v.

ERIC D. HARGAN, in his official capacity
as Acting Secretary of the U.S. Department
of Health and Human Services; U.S.
DEPARTMENT OF HEALTH AND
HUMAN SERVICES; R. ALEXANDER
ACOSTA, in his official capacity as
Secretary of U.S. Department of Labor; U.S.
DEPARTMENT OF LABOR; STEVEN
MNUCHIN, in his official capacity as
Secretary of the U.S. Department of the
Treasury; U.S. DEPARTMENT OF THE
TREASURY; DOES 1-100,

Defendants,

and,

THE LITTLE SISTERS OF THE POOR
JEANNE JUGAN RESIDENCE,

Intervenor-Defendants.

Case No. 4:17-cv-05783-HSG

**DECLARATION OF MOTHER
SUPERIOR MARGUERITE MARIE
MCCARTHY**

1 I, Mother Superior Marguerite Marie McCarthy, hereby declare as follows:

2 1. I am over the age of 21 and am capable of making this declaration pursuant to
3 28 U.S.C. § 1746. I have not been convicted of a felony or crime involving dishonesty. I
4 make this declaration based on my personal knowledge and experience of the Little
5 Sisters, our organization, our ministry, and our religious beliefs and practices. My
6 statements about the history of the Little Sisters, the scope of our ministry
7 internationally, and the founding dates of our homes are drawn from organizational and
8 historical documents that I believe to be correct.
9

10 2. I am the Mother Superior of the Jeanne Jugan Residence of the Little Sisters of
11 the Poor in San Pedro, California.

12 3. I have been a Little Sister for 57 years, and have served in leadership positions
13 in the order for 42 years, with over 3 years at the Jeanne Jugan Residence.

14 **I. History, Organization, and Structure of the Little Sisters of the Poor**

15 4. The Little Sisters of the Poor is an international Roman Catholic Congregation
16 of Sisters that has provided loving care to needy elderly persons of any race, sex, or
17 religion for over 175 years.
18

19 5. The Little Sisters of the Poor were founded in France, in the winter of 1839,
20 when St. Jeanne Jugan carried a blind elderly woman off the streets and into her home
21 and laid the woman in her own bed. Over time, other women joined St. Jeanne in a
22 religious ministry designed to protect and care for the elderly poor.

23 6. By the time St. Jeanne died forty years later, the Little Sisters of the Poor had
24 established homes in eight countries, including the United States, where the first home
25 was founded in 1868 in Brooklyn, New York.
26

1 7. Today, there are Little Sisters homes in over thirty countries around the world
2 serving over 13,000 poor elderly people.

3 8. The Little Sisters of the Poor have founded and operate over twenty-five homes
4 in the United States, which are located in twenty states and the District of Columbia.
5 These homes are hosted by over 300 Little Sisters of various nationalities.

6 9. All Little Sisters homes share the same fidelity to the Catholic beliefs. Every
7 home is operated under the control of the Little Sisters, and every Little Sister takes a
8 vow of obedience to God, which assumes obedience to the Pope, the Church's teaching,
9 and the authority of the Church in her hierarchy.

10 10. While Catholic and committed to following Church teaching, the Little Sisters'
11 homes are not under the civil legal ownership and control of the dioceses in which they
12 are located. Instead, the Little Sisters of the Poor own and control the homes ourselves,
13 through local corporations that are entirely within the civil legal control of the Little
14 Sisters.

15 11. The Little Sisters' homes are not directly funded by the dioceses in which we are
16 located. Instead, we take responsibility for funding our own operations. For most homes,
17 about half of the budget comes from voluntary gifts, largely in response to the begging
18 for funds and gifts in kind that the Little Sisters do to support our ministry.

19 **II. Little Sisters of the Poor San Pedro**

20 12. The Jeanne Jugan Residence of the Little Sisters of the Poor in San Pedro
21 ("Little Sisters San Pedro"), is a California non-profit corporation that qualifies as a tax-
22 exempt organization under section 501(c)(3) of the Internal Revenue Code of 1986 ("the
23 Code"). The San Pedro home is under my direct authority as Mother Superior.

13. Little Sisters San Pedro currently employs about 84 full-time employees.

14. Little Sisters San Pedro have adopted the Christian Brothers Employee Benefit Trust (the “Christian Brothers Trust”) to provide medical benefits coverage for their employees.

15. It is my understanding that Christian Brothers Trust is a Catholic entity designed to serve the Catholic Church and related faith-based entities. It is my understanding that, like the Little Sisters, the Christian Brothers Trust operates in a manner consistent with our mutual Catholic beliefs. One of the reasons the Little Sisters chose to use the Christian Brothers Trust for our health benefits is because it shares and is administered in accordance with our religious beliefs and provide benefits accordingly.

III. Religious Beliefs and Commitments of the Little Sisters of the Poor

16. Jesus taught that “in so far as you did it to the least of these brothers of mine, you did it to me.” *See* Matthew 25:34. This teaching is a fundamental part of who the Little Sisters are. St. Jeanne urged her fellow Little Sisters, “Never forget that the poor are Our Lord; in caring for the poor say to yourself: This is for my Jesus—what a great grace!” Thus, each Little Sister makes a vow of Hospitality, through which she promises to care for the aged as if they were Christ himself.

17. As Little Sisters, we strive to witness to the value of the elderly by believing in their inviolable dignity, by recognizing their unique contributions to the Church and society, and by involving them in the activities of our Homes to develop their human potential.

18. Caring for the dying is the summit of the Little Sisters’ service to the elderly poor. The Little Sisters maintain a constant presence with those who have entered the

1 dying process and their families. We try to relieve their sufferings as much as possible,
2 which includes giving emotional and prayerful support. Our provision of spiritual
3 support is always consistent with the faith of the person we are serving; we do not force
4 religious observance on anyone.

5 19. Because the Little Sisters care for those who are weak and dying, we strive to
6 emphasize our respect for the uniqueness and dignity of each elderly person as they
7 reach the end of their life. We offer this respect for two reasons. First, to treat the
8 individual with the dignity they are due as a person loved and created by God, with the
9 same respect and compassion as if he or she was Jesus Christ. Second, to convey a public
10 witness of respect for life, in the hope that we can help build a Culture of Life in our
11 society.
12

13 20. We care for the elderly poor of all races and religions, or of no religion at all. We
14 do not care for people because they are Catholic, but because we are Catholic.
15

16 21. We also hire employees of all races and religions, or of no religion at all. Because
17 staff members are an important extension of our ministry to the elderly, they must
18 support the Little Sisters' mission by welcoming the elderly poor, helping to make them
19 happy and caring for them with respect or dignity until death. Failure to do so is one of
20 the relatively few explicit grounds for staff dismissal.

21 22. The Little Sisters have also taken a vow of obedience to God, which assumes
22 obedience to the Pope. We carefully follow all of his guidance, and obey all the decisions
23 of the Church. Thus, we develop all of our programs, policies, and procedures in accord
24 with the teachings of the Catholic Church, including its ethical teachings on the
25 inviolable dignity of every human life.
26

1 23. These teachings include Catholic religious teachings about abortion,
2 contraception, sterilization, and cooperation with acts that are intrinsically immoral.

3 24. Authoritative Catholic teachings are located in sacred Scripture and sacred
4 tradition, and are set forth and specified in the Catechism of the Catholic Church,
5 documents of ecumenical councils (such as the Second Vatican Council), papal
6 encyclicals, directives issued by bishops' conferences, and other teaching documents of
7 the Church. *See generally* Catechism of the Catholic Church Nos. 888-892 (describing
8 the teaching office of the Church); *Dei Verbum* No. 10 (describing how “[s]acred tradition
9 and Sacred Scripture form one sacred deposit of the word of God, committed to the
10 Church”).

11
12 25. Sections 2270 and 2271 of the Catechism of the Catholic Church (1994) affirm
13 that life begins at conception, that directly intending to take innocent human life is
14 gravely immoral. Thus a post-conception contraceptive is an abortifacient and “gravely
15 contrary to moral law.” *See also* section 2274 (“Since it must be treated from conception
16 as a person, the embryo must be defended in its integrity, cared for, and healed, as far
17 as possible, like any other human being.”)

18
19 26. The Catholic Church also teaches that contraception and sterilization are
20 intrinsic evils. *Id.* at Section 2370.

21 27. The Church teaches that programs of “economic assistance aimed at financing
22 campaigns of sterilization and contraception” are “affronts to the dignity of the person
23 and the family.” *See* Section 234 of the Compendium of the Social Doctrine of the Church
24 (2004).

1 28. In a landmark encyclical, Blessed Pope John Paul II made clear that Catholics
2 may never “encourage” the use of “contraception, sterilization, and abortion[.]” See
3 Section 91 of *Evangelium Vitae* (1995).

4 29. Similarly, the United States Conference of Catholic Bishops (“USCCB”) has
5 issued a series of directives to inform the provision of health services in every U.S.
6 Catholic health institution. These directives prohibit providing, promoting, condoning,
7 or participating in the provision of abortions, abortion-inducing drugs, contraceptives,
8 and sterilization. Exhibit A, USCCB Directives for Catholic Health Care Services at Nos.
9 45, 52, & 53.

10 30. The directives specifically warn against partnering with other entities in a
11 manner that could involve Catholic health care services in the provision of such
12 “intrinsically immoral” services. *Id.* at Nos. 67-72.

13 31. Rather, the USCCB Directives instruct us to “distinguish [ourselves] by service
14 to and advocacy for” people who are “at the margins of society” and “particularly
15 vulnerable to discrimination,” such as “the poor, the uninsured and underinsured;
16 children and the unborn; single parents; the elderly; those with incurable diseases and
17 chemical dependencies; racial minorities; immigrants and refugees.” *Id.* at No. 3.

18 32. The Little Sisters are particularly concerned about the possibility that our
19 conduct may lead others to do evil, or think that the Little Sisters condone evil. See
20 Catechism No. 2284, 86 (instructing Catholic institutions to avoid “scandal” and defining
21 “scandal” as “an attitude or behavior which leads another to do evil”; scandal can be
22 caused “by laws or institutions”). The Little Sisters beg for funds and goods at Catholic
23 parishes and elsewhere to support our ministry. Thus, participating in the provision of
24
25
26

1 health benefits that violate Catholic teaching poses a grave risk for the Little Sisters as
2 they interact with Catholic faithful and others who share our beliefs.

3 33. Catholic teaching also instructs us to provide our employees and their families
4 adequate health benefits. “In return for their labor, workers have a right to wages and
5 other benefits sufficient to sustain life in dignity.” *Economic Justice For All: Pastoral*
6 *Letter on Catholic Social Teaching and the U.S. Economy* ¶ 103,
7 http://www.usccb.org/upload/economic_justice_for_all.pdf (“The dignity of workers also
8 requires adequate health care”).
9

10 34. These religious teachings binding on how the Little Sisters carry out our
11 religious ministry of caring for the elderly poor. We believe that the health plans that
12 each home offers should be consistent with Catholic teaching.

13 **IV. The Impact of the Mandate on the Little Sisters**

14 35. The HHS contraceptive mandate (the “Mandate”) requires the Little Sisters to
15 participate in the provision of contraception, abortion, and sterilization to our employees
16 via the use of our health plans, health plan information, and health plan infrastructure.
17 If we do not comply with the Mandate, we face massive penalties, which places enormous
18 pressure on the Little Sisters to violate our religious beliefs.
19

20 36. Our vow of hospitality, which asks us to treat each person in our care as if he or
21 she were Christ himself, commits us just as much to respecting the dignity of human life
22 at its beginning as at its end. We can no more participate in the provision of
23 contraception, abortion, and sterilization than we could participate in the provision of
24 euthanasia or assisted suicide.
25

26 37. Because of the religious beliefs set forth above, the Little Sisters cannot:

- a. participate in the Mandate's program to promote and facilitate access to the use of sterilization, contraceptives, and abortion-inducing drugs and devices,
- b. provide health benefits to our employees and plan beneficiaries that will include or facilitate access to sterilization, contraception, and abortion-inducing drugs and devices,
- c. designate, authorize, or incentivize any third party to provide our employees or plan beneficiaries with access to sterilization, contraception, and abortion-inducing drugs and devices,
- d. sign, execute, deliver, or otherwise file documents with a third party or with the government which could then be used to require, authorize, or incentivize that third party to provide our employees with access to sterilization, contraception, and abortion-inducing drugs;
- e. agree to refrain from speaking with a third party to ask or instruct it not to deliver contraceptives, sterilization, and abortifacients to Little Sisters' employees and plan beneficiaries in connection with Little Sisters' health plans;
- f. create or facilitate a provider-insured relationship (between the Little Sisters and Christian Brothers Services or any other third-party administrators), the sole purpose of which would be to provide contraceptives, sterilization, and abortifacients in connection with the Little Sisters' health plans;

1 g. create, maintain, support, and facilitate health insurance plans,
2 information, and infrastructure that is used to provide contraceptives,
3 sterilization, and abortifacients to Little Sisters' employees and plan
4 beneficiaries;

5 h. take any action that would require, authorize, or incentivize Christian
6 Brothers Trust or Christian Brothers Services to violate their own Catholic
7 religious beliefs.
8

9 38. Obeying the Mandate's requirement to participate in the provision of abortion-
10 inducing drugs would violate our public witness to the respect for life and human dignity
11 that we are committed to displaying at all times through our vow of hospitality and our
12 fidelity to Church teaching. It would similarly violate our duty to "advoca[te] for those
13 people whose social condition puts them at the margins of our society and makes them
14 particularly vulnerable," such as "the unborn." Exhibit A, USCCB Directives, at No. 3.

15 39. The Little Sisters believe that our ministry and all of our resources—including
16 our health insurance plans and the efforts we make to maintain those plans—are gifts
17 from God that we must use to God's glory and for the good of all, to help bear the burdens
18 and sufferings of others. We cannot allow those gifts to be co-opted to serve ends that we
19 believe dishonor God and the dignity of the human person.
20

21 40. The Mandate threatens the Little Sisters with large fines and penalties if we
22 continue to act in accordance with our religious beliefs.

23 41. For example, if we continue our practice of providing health benefits to our
24 employees and their families without including or facilitating free access to sterilization,
25 contraception, and abortion-inducing drugs and devices, we will face fines of "\$100 for
26

1 each day in the noncompliance period with respect to each individual to whom such
2 failure relates.” 26 U.S.C. § 4980D(b)(1).

3 42. Depending on how the I.R.S. applied this penalty, the Little Sisters homes could
4 face tens of millions of dollars of fines *each year* for our inability to facilitate the required
5 coverage.

6 43. Little Sisters San Pedro currently employs about 84 full-time employees. If the
7 I.R.S. levies the fine on a per-full-time-employee basis, we would be facing daily fines of
8 \$8,400, and annual fines of \$3,066,000. If the I.R.S. levies the fine on the basis of total
9 number of employees and dependents receiving benefits, the fines would be orders of
10 magnitude larger.

11 44. The entire annual budget for Little Sisters San Pedro, which currently provides
12 care for 103 needy elderly individuals, is \$5,400,000.

13 45. Nor can we avoid these fines by choosing not to provide health benefits at all.
14 Cutting off all benefits for our employees would be unconscionable. We love and respect
15 our employees and are dedicated to providing adequate health benefits.

16 46. Cutting off all employee benefits would also have a severe negative impact on
17 our employees and their families, and on our ability to hire and retain qualified medical
18 staff and other employees. Benefits plans are an important reason that many employees
19 make choices about which jobs to pursue, to keep, and to abandon.

20 47. Even if we could cut off all benefits in good conscience and without harming our
21 employees or our homes, we would face large government fines for doing so. For example,
22 Little Sisters-San Pedro would face annual fines of approximately \$168,000 for dropping
23 health benefits altogether.
24
25
26

1 48. For these reasons, the Mandate imposes enormous pressure on the Little Sisters
2 to participate in activities prohibited by our sincerely held religious beliefs.

3 49. Prior to the Mandate, we engaged in conduct motivated by our sincerely held
4 religious beliefs: providing benefits plans that do not include sterilization, contraception,
5 and abortion-inducing drugs and devices. The Mandate penalizes our participation in
6 that religious exercise.

7
8 50. The Mandate also places enormous pressure on the Little Sisters to engage in
9 conduct contrary to our sincerely held religious beliefs. I am charged with making
10 decisions for the Little Sisters-San Pedro. The severe threats of fines and punishment
11 create enormous pressure on me to violate my religious beliefs as the price of continuing
12 our mission of helping the needy elderly.

13 51. We object to the Mandate not because it makes us *use* drugs or devices against
14 our religious beliefs, but because it forces us to participate as a necessary part of the
15 government's scheme to provide those drugs and devices.

16
17 **The Little Sisters' Litigation Against the Mandate**

18 52. The Little Sisters tried to avoid having to sue the federal government to protect
19 our ministry. We made multiple public statements and filed a detailed public comment
20 with the federal government to inform it of our sincere religious objection to
21 incorporating us into its scheme. But the government refused to exempt us. Which meant
22 that on January 1, 2014, we would start facing massive penalties.

23 53. We filed suit on September 24, 2013, and filed a motion for preliminary
24 injunction one month later, on October 24. *Little Sisters of the Poor v. Sebelius*, No. 13-
25 cv-2611 (D. Colo.).

1 54. Over the next four years, we would remain in constant litigation with the federal
2 government. We twice had to go to the Supreme Court to be protected from the imposition
3 of massive financial penalties.

4 55. The first time came on December 31, 2013, when just hours before the start of
5 the penalties we filed for and received a temporary emergency injunction from Justice
6 Sotomayor just hours. Later in January 2014, the rest of the Supreme Court would grant
7 an injunction pending appeal without noted dissent. *Little Sisters of the Poor v. Sebelius*,
8 134 S. Ct. 1022 (2014).
9

10 56. And the second time came after the Supreme Court granted certiorari in our
11 case, when it vacated a Tenth Circuit ruling against us, remanded the case for further
12 consideration, and ordered that “the Government may not impose taxes or penalties” on
13 us while the case remained pending. *Zubik v. Burwell*, 136 S. Ct. 1557 (2016).
14

15 57. Our case has remained pending at the Tenth Circuit since that time.

16 **The Interim Final Rule**

17 58. On May 4, 2017, President Trump invited members of the Little Sisters of the
18 Poor to the White House for the traditional proclamation of the National Day of Prayer
19 and the signing of an Executive Order related to religious liberty.

20 59. At the signing ceremony, the President made clear that the Mandate’s
21 application to the Little Sisters had been inappropriate and illegal. The President
22 described the Mandate as an “attack[] against the Little Sisters of the Poor” that had
23 put them through “a long, hard ordeal,” and he listed it as an example of past “abuses”
24 of religious liberty. See [https://www.c-span.org/video/?428059-1/president-trump-](https://www.c-span.org/video/?428059-1/president-trump-signsreligious-liberty-executive-order)
25 [signsreligious-liberty-executive-order](https://www.c-span.org/video/?428059-1/president-trump-signsreligious-liberty-executive-order) (starting at 28:30).
26

1 60. The agencies issued an Interim Final Rule on October 6, 2017. *See* Religious
2 Exemptions and Accommodations for Coverage of Certain Preventive Services Under the
3 Affordable Care Act, 82 Fed. Reg. 47792 (Oct. 13, 2017). The rule explicitly referred to
4 the Little Sisters’ lawsuit and the Supreme Court decision in our case as the impetus for
5 the regulatory change: “Consistent with the President’s Executive Order and the
6 Government’s desire to resolve the pending litigation and prevent future litigation from
7 similar plaintiffs, the Departments have concluded that it is appropriate to reexamine
8 the exemption and accommodation scheme currently in place for the Mandate.” 82 Fed.
9 Reg. 47799; *see also id.* at 47798 (describing lawsuits and *Zubik* decision).

11 61. The Interim Final Rule conceded that “requiring certain objecting entities or
12 individuals to choose between the Mandate, the accommodation, or penalties for
13 noncompliance imposes a substantial burden on religious exercise under RFRA,” and
14 that because “requiring such compliance did not serve a compelling interest and was not
15 the least restrictive means of serving a compelling interest, we now believe that
16 requiring such compliance led to the violation of RFRA in many instances.” *Id.* at 47800,
17 47806.

19 **Conclusion**

20 62. Being forced into four years of litigation, including two trips to the Supreme
21 Court, has been a difficult and burdensome experience for the Little Sisters. We do not
22 want to alarm in any way the elderly poor whom we serve, nor their families, our
23 employees, or our benefactors. But to protect our ability to serve them as we always have,
24 and to avoid violating and publicly rejecting our religious beliefs, our only recourse was
25 a lawsuit.

1 63. It is deeply troubling to us that, after years of respectfully seeking recourse in
2 federal court to be protected from the *federal* government, we are being forced to defend
3 those same rights that are threatened by a *state* government. We had never been
4 required to provide these objectionable services by California, and do not understand
5 why California asks this Court to force us to provide them now. We hope a day will come
6 when government will cease threatening our ministry in this way.
7

1 I declare under penalty of perjury under the laws of the United States that the
2 foregoing is true and correct.
3

4 Executed this 17th day of November, 2017,
5

6 *Mother Superior Marguerite Marie*
7 Mother Superior Marguerite Marie McCarthy *McCarthy*
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EXHIBIT A



Issued by USCCB, November 17, 2009

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Ethical and Religious Directives for Catholic Health Care Services

Fifth Edition

United States Conference of Catholic Bishops

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PREAMBLE

Health care in the United States is marked by extraordinary change. Not only is there continuing change in clinical practice due to technological advances, but the health care system in the United States is being challenged by both institutional and social factors as well. At the same time, there are a number of developments within the Catholic Church affecting the ecclesial mission of health care. Among these are significant changes in religious orders and congregations, the increased involvement of lay men and women, a heightened awareness of the Church's social role in the world, and developments in moral theology since the Second Vatican Council. A contemporary understanding of the Catholic health care ministry must take into account the new challenges presented by transitions both in the Church and in American society.

Throughout the centuries, with the aid of other sciences, a body of moral principles has emerged that expresses the Church's teaching on medical and moral matters and has proven to be pertinent and applicable to the ever-changing circumstances of health care and its delivery. In response to today's challenges, these same moral principles of Catholic teaching provide the rationale and direction for this revision of the *Ethical and Religious Directives for Catholic Health Care Services*.

These Directives presuppose our statement *Health and Health Care* published in 1981.¹ There we presented the theological principles that guide the Church's vision of health care, called for all Catholics to share in the healing mission of the Church, expressed our full commitment to the health care ministry, and offered encouragement to all those who are involved in it. Now, with American health care facing even more dramatic changes, we reaffirm the Church's commitment to health care ministry and the distinctive Catholic identity of the Church's institutional health care services.² The purpose of these *Ethical and Religious*

Directives then is twofold: first, to reaffirm the ethical standards of behavior in health care that flow from the Church's teaching about the dignity of the human person; second, to provide authoritative guidance on certain moral issues that face Catholic health care today.

The *Ethical and Religious Directives* are concerned primarily with institutionally based Catholic health care services. They address the sponsors, trustees, administrators, chaplains, physicians, health care personnel, and patients or residents of these institutions and services. Since they express the Church's moral teaching, these Directives also will be helpful to Catholic professionals engaged in health care services in other settings. The moral teachings that we profess here flow principally from the natural law, understood in the light of the revelation Christ has entrusted to his Church. From this source the Church has derived its understanding of the nature of the human person, of human acts, and of the goals that shape human activity.

The Directives have been refined through an extensive process of consultation with bishops, theologians, sponsors, administrators, physicians, and other health care providers. While providing standards and guidance, the Directives do not cover in detail all of the complex issues that confront Catholic health care today. Moreover, the Directives will be reviewed periodically by the United States Conference of Catholic Bishops (formerly the National Conference of Catholic Bishops), in the light of authoritative church teaching, in order to address new insights from theological and medical research or new requirements of public policy.

The Directives begin with a general introduction that presents a theological basis for the Catholic health care ministry. Each of the six parts that follow is divided into two sections. The first section is in expository form; it serves as an introduction and provides the context in which concrete issues can be discussed from the perspective of the Catholic faith. The second section is

in prescriptive form; the directives promote and protect the truths of the Catholic faith as those truths are brought to bear on concrete issues in health care.

GENERAL INTRODUCTION

The Church has always sought to embody our Savior's concern for the sick. The gospel accounts of Jesus' ministry draw special attention to his acts of healing: he cleansed a man with leprosy (Mt 8:1-4; Mk 1:40-42); he gave sight to two people who were blind (Mt 20:29-34; Mk 10:46-52); he enabled one who was mute to speak (Lk 11:14); he cured a woman who was hemorrhaging (Mt 9:20-22; Mk 5:25-34); and he brought a young girl back to life (Mt 9:18, 23-25; Mk 5:35-42). Indeed, the Gospels are replete with examples of how the Lord cured every kind of ailment and disease (Mt 9:35). In the account of Matthew, Jesus' mission fulfilled the prophecy of Isaiah: "He took away our infirmities and bore our diseases" (Mt 8:17; cf. Is 53:4).

Jesus' healing mission went further than caring only for physical affliction. He touched people at the deepest level of their existence; he sought their physical, mental, and spiritual healing (Jn 6:35, 11:25-27). He "came so that they might have life and have it more abundantly" (Jn 10:10).

The mystery of Christ casts light on every facet of Catholic health care: to see Christian love as the animating principle of health care; to see healing and compassion as a continuation of Christ's mission; to see suffering as a participation in the redemptive power of Christ's passion, death, and resurrection; and to see death, transformed by the resurrection, as an opportunity for a final act of communion with Christ.

For the Christian, our encounter with suffering and death can take on a positive and distinctive meaning through the redemptive power of Jesus' suffering and death. As St. Paul says, we are "always carrying about in the body the dying of Jesus, so that the life of Jesus may also be manifested in our body" (2 Cor 4:10). This truth does not lessen the pain and fear, but gives confidence and grace for bearing suffering rather than being overwhelmed by it. Catholic

health care ministry bears witness to the truth that, for those who are in Christ, suffering and death are the birth pangs of the new creation. “God himself will always be with them [as their God]. He will wipe every tear from their eyes, and there shall be no more death or mourning, wailing or pain, [for] the old order has passed away” (Rev 21:3-4).

In faithful imitation of Jesus Christ, the Church has served the sick, suffering, and dying in various ways throughout history. The zealous service of individuals and communities has provided shelter for the traveler; infirmaries for the sick; and homes for children, adults, and the elderly.³ In the United States, the many religious communities as well as dioceses that sponsor and staff this country’s Catholic health care institutions and services have established an effective Catholic presence in health care. Modeling their efforts on the gospel parable of the Good Samaritan, these communities of women and men have exemplified authentic neighborliness to those in need (Lk 10:25-37). The Church seeks to ensure that the service offered in the past will be continued into the future.

While many religious communities continue their commitment to the health care ministry, lay Catholics increasingly have stepped forward to collaborate in this ministry. Inspired by the example of Christ and mandated by the Second Vatican Council, lay faithful are invited to a broader and more intense field of ministries than in the past.⁴ By virtue of their Baptism, lay faithful are called to participate actively in the Church’s life and mission.⁵ Their participation and leadership in the health care ministry, through new forms of sponsorship and governance of institutional Catholic health care, are essential for the Church to continue her ministry of healing and compassion. They are joined in the Church’s health care mission by many men and women who are not Catholic.

Catholic health care expresses the healing ministry of Christ in a specific way within the local church. Here the diocesan bishop exercises responsibilities that are rooted in his office as pastor, teacher, and priest. As the center of unity in the diocese and coordinator of ministries in the local church, the diocesan bishop fosters the mission of Catholic health care in a way that promotes collaboration among health care leaders, providers, medical professionals, theologians, and other specialists. As pastor, the diocesan bishop is in a unique position to encourage the faithful to greater responsibility in the healing ministry of the Church. As teacher, the diocesan bishop ensures the moral and religious identity of the health care ministry in whatever setting it is carried out in the diocese. As priest, the diocesan bishop oversees the sacramental care of the sick. These responsibilities will require that Catholic health care providers and the diocesan bishop engage in ongoing communication on ethical and pastoral matters that require his attention.

In a time of new medical discoveries, rapid technological developments, and social change, what is new can either be an opportunity for genuine advancement in human culture, or it can lead to policies and actions that are contrary to the true dignity and vocation of the human person. In consultation with medical professionals, church leaders review these developments, judge them according to the principles of right reason and the ultimate standard of revealed truth, and offer authoritative teaching and guidance about the moral and pastoral responsibilities entailed by the Christian faith.⁶ While the Church cannot furnish a ready answer to every moral dilemma, there are many questions about which she provides normative guidance and direction. In the absence of a determination by the magisterium, but never contrary to church teaching, the guidance of approved authors can offer appropriate guidance for ethical decision making.

Created in God's image and likeness, the human family shares in the dominion that Christ manifested in his healing ministry. This sharing involves a stewardship over all material creation (Gn 1:26) that should neither abuse nor squander nature's resources. Through science the human race comes to understand God's wonderful work; and through technology it must conserve, protect, and perfect nature in harmony with God's purposes. Health care professionals pursue a special vocation to share in carrying forth God's life-giving and healing work.

The dialogue between medical science and Christian faith has for its primary purpose the common good of all human persons. It presupposes that science and faith do not contradict each other. Both are grounded in respect for truth and freedom. As new knowledge and new technologies expand, each person must form a correct conscience based on the moral norms for proper health care.

PART ONE

The Social Responsibility of Catholic Health Care Services

Introduction

Their embrace of Christ's healing mission has led institutionally based Catholic health care services in the United States to become an integral part of the nation's health care system. Today, this complex health care system confronts a range of economic, technological, social, and moral challenges. The response of Catholic health care institutions and services to these challenges is guided by normative principles that inform the Church's healing ministry.

First, Catholic health care ministry is rooted in a commitment to promote and defend human dignity; this is the foundation of its concern to respect the sacredness of every human life from the moment of conception until death. The first right of the human person, the right to life, entails a right to the means for the proper development of life, such as adequate health care.⁷

Second, the biblical mandate to care for the poor requires us to express this in concrete action at all levels of Catholic health care. This mandate prompts us to work to ensure that our country's health care delivery system provides adequate health care for the poor. In Catholic institutions, particular attention should be given to the health care needs of the poor, the uninsured, and the underinsured.⁸

Third, Catholic health care ministry seeks to contribute to the common good. The common good is realized when economic, political, and social conditions ensure protection for the fundamental rights of all individuals and enable all to fulfill their common purpose and reach their common goals.⁹

Fourth, Catholic health care ministry exercises responsible stewardship of available health care resources. A just health care system will be concerned both with promoting equity of care—to assure that the right of each person to basic health care is respected—and with promoting the good health of all in the community. The responsible stewardship of health care resources can be accomplished best in dialogue with people from all levels of society, in accordance with the principle of subsidiarity and with respect for the moral principles that guide institutions and persons.

Fifth, within a pluralistic society, Catholic health care services will encounter requests for medical procedures contrary to the moral teachings of the Church. Catholic health care does not offend the rights of individual conscience by refusing to provide or permit medical procedures that are judged morally wrong by the teaching authority of the Church.

Directives

1. A Catholic institutional health care service is a community that provides health care to those in need of it. This service must be animated by the Gospel of Jesus Christ and guided by the moral tradition of the Church.

2. Catholic health care should be marked by a spirit of mutual respect among caregivers that disposes them to deal with those it serves and their families with the compassion of Christ, sensitive to their vulnerability at a time of special need.

3. In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor; the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; racial minorities; immigrants and refugees. In particular, the person

with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons.

4. A Catholic health care institution, especially a teaching hospital, will promote medical research consistent with its mission of providing health care and with concern for the responsible stewardship of health care resources. Such medical research must adhere to Catholic moral principles.

5. Catholic health care services must adopt these Directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel.

6. A Catholic health care organization should be a responsible steward of the health care resources available to it. Collaboration with other health care providers, in ways that do not compromise Catholic social and moral teaching, can be an effective means of such stewardship.¹⁰

7. A Catholic health care institution must treat its employees respectfully and justly. This responsibility includes: equal employment opportunities for anyone qualified for the task, irrespective of a person's race, sex, age, national origin, or disability; a workplace that promotes employee participation; a work environment that ensures employee safety and well-being; just compensation and benefits; and recognition of the rights of employees to organize and bargain collectively without prejudice to the common good.

8. Catholic health care institutions have a unique relationship to both the Church and the wider community they serve. Because of the ecclesial nature of this relationship, the relevant

requirements of canon law will be observed with regard to the foundation of a new Catholic health care institution; the substantial revision of the mission of an institution; and the sale, sponsorship transfer, or closure of an existing institution.

9. Employees of a Catholic health care institution must respect and uphold the religious mission of the institution and adhere to these Directives. They should maintain professional standards and promote the institution's commitment to human dignity and the common good.

PART TWO

The Pastoral and Spiritual Responsibility of Catholic Health Care

Introduction

The dignity of human life flows from creation in the image of God (Gn 1:26), from redemption by Jesus Christ (Eph 1:10; 1 Tm 2:4-6), and from our common destiny to share a life with God beyond all corruption (1 Cor 15:42-57). Catholic health care has the responsibility to treat those in need in a way that respects the human dignity and eternal destiny of all. The words of Christ have provided inspiration for Catholic health care: “I was ill and you cared for me” (Mt 25:36). The care provided assists those in need to experience their own dignity and value, especially when these are obscured by the burdens of illness or the anxiety of imminent death.

Since a Catholic health care institution is a community of healing and compassion, the care offered is not limited to the treatment of a disease or bodily ailment but embraces the physical, psychological, social, and spiritual dimensions of the human person. The medical expertise offered through Catholic health care is combined with other forms of care to promote health and relieve human suffering. For this reason, Catholic health care extends to the spiritual nature of the person. “Without health of the spirit, high technology focused strictly on the body offers limited hope for healing the whole person.”¹¹ Directed to spiritual needs that are often appreciated more deeply during times of illness, pastoral care is an integral part of Catholic health care. Pastoral care encompasses the full range of spiritual services, including a listening presence; help in dealing with powerlessness, pain, and alienation; and assistance in recognizing and responding to God’s will with greater joy and peace. It should be acknowledged, of course, that technological advances in medicine have reduced the length of hospital stays dramatically. It

follows, therefore, that the pastoral care of patients, especially administration of the sacraments, will be provided more often than not at the parish level, both before and after one's hospitalization. For this reason, it is essential that there be very cordial and cooperative relationships between the personnel of pastoral care departments and the local clergy and ministers of care.

Priests, deacons, religious, and laity exercise diverse but complementary roles in this pastoral care. Since many areas of pastoral care call upon the creative response of these pastoral caregivers to the particular needs of patients or residents, the following directives address only a limited number of specific pastoral activities.

Directives

10. A Catholic health care organization should provide pastoral care to minister to the religious and spiritual needs of all those it serves. Pastoral care personnel—clergy, religious, and lay alike—should have appropriate professional preparation, including an understanding of these Directives.

11. Pastoral care personnel should work in close collaboration with local parishes and community clergy. Appropriate pastoral services and/or referrals should be available to all in keeping with their religious beliefs or affiliation.

12. For Catholic patients or residents, provision for the sacraments is an especially important part of Catholic health care ministry. Every effort should be made to have priests assigned to hospitals and health care institutions to celebrate the Eucharist and provide the sacraments to patients and staff.

13. Particular care should be taken to provide and to publicize opportunities for patients or residents to receive the sacrament of Penance.

14. Properly prepared lay Catholics can be appointed to serve as extraordinary ministers of Holy Communion, in accordance with canon law and the policies of the local diocese. They should assist pastoral care personnel—clergy, religious, and laity—by providing supportive visits, advising patients regarding the availability of priests for the sacrament of Penance, and distributing Holy Communion to the faithful who request it.

15. Responsive to a patient's desires and condition, all involved in pastoral care should facilitate the availability of priests to provide the sacrament of Anointing of the Sick, recognizing that through this sacrament Christ provides grace and support to those who are seriously ill or weakened by advanced age. Normally, the sacrament is celebrated when the sick person is fully conscious. It may be conferred upon the sick who have lost consciousness or the use of reason, if there is reason to believe that they would have asked for the sacrament while in control of their faculties.

16. All Catholics who are capable of receiving Communion should receive Viaticum when they are in danger of death, while still in full possession of their faculties.¹²

17. Except in cases of emergency (i.e., danger of death), any request for Baptism made by adults or for infants should be referred to the chaplain of the institution. Newly born infants in danger of death, including those miscarried, should be baptized if this is possible.¹³ In case of emergency, if a priest or a deacon is not available, anyone can validly baptize.¹⁴ In the case of emergency Baptism, the chaplain or the director of pastoral care is to be notified.

18. When a Catholic who has been baptized but not yet confirmed is in danger of death, any priest may confirm the person.¹⁵

19. A record of the conferral of Baptism or Confirmation should be sent to the parish in which the institution is located and posted in its baptism/confirmation registers.

20. Catholic discipline generally reserves the reception of the sacraments to Catholics. In accord with canon 844, §3, Catholic ministers may administer the sacraments of Eucharist, Penance, and Anointing of the Sick to members of the oriental churches that do not have full communion with the Catholic Church, or of other churches that in the judgment of the Holy See are in the same condition as the oriental churches, if such persons ask for the sacraments on their own and are properly disposed.

With regard to other Christians not in full communion with the Catholic Church, when the danger of death or other grave necessity is present, the four conditions of canon 844, §4, also must be present, namely, they cannot approach a minister of their own community; they ask for the sacraments on their own; they manifest Catholic faith in these sacraments; and they are properly disposed. The diocesan bishop has the responsibility to oversee this pastoral practice.

21. The appointment of priests and deacons to the pastoral care staff of a Catholic institution must have the explicit approval or confirmation of the local bishop in collaboration with the administration of the institution. The appointment of the director of the pastoral care staff should be made in consultation with the diocesan bishop.

22. For the sake of appropriate ecumenical and interfaith relations, a diocesan policy should be developed with regard to the appointment of non-Catholic members to the pastoral care staff of a Catholic health care institution. The director of pastoral care at a Catholic institution should be a Catholic; any exception to this norm should be approved by the diocesan bishop.

PART THREE

The Professional-Patient Relationship

Introduction

A person in need of health care and the professional health care provider who accepts that person as a patient enter into a relationship that requires, among other things, mutual respect, trust, honesty, and appropriate confidentiality. The resulting free exchange of information must avoid manipulation, intimidation, or condescension. Such a relationship enables the patient to disclose personal information needed for effective care and permits the health care provider to use his or her professional competence most effectively to maintain or restore the patient's health. Neither the health care professional nor the patient acts independently of the other; both participate in the healing process.

Today, a patient often receives health care from a team of providers, especially in the setting of the modern acute-care hospital. But the resulting multiplication of relationships does not alter the personal character of the interaction between health care providers and the patient. The relationship of the person seeking health care and the professionals providing that care is an important part of the foundation on which diagnosis and care are provided. Diagnosis and care, therefore, entail a series of decisions with ethical as well as medical dimensions. The health care professional has the knowledge and experience to pursue the goals of healing, the maintenance of health, and the compassionate care of the dying, taking into account the patient's convictions and spiritual needs, and the moral responsibilities of all concerned. The person in need of health care depends on the skill of the health care provider to assist in preserving life and promoting

health of body, mind, and spirit. The patient, in turn, has a responsibility to use these physical and mental resources in the service of moral and spiritual goals to the best of his or her ability.

When the health care professional and the patient use institutional Catholic health care, they also accept its public commitment to the Church's understanding of and witness to the dignity of the human person. The Church's moral teaching on health care nurtures a truly interpersonal professional-patient relationship. This professional-patient relationship is never separated, then, from the Catholic identity of the health care institution. The faith that inspires Catholic health care guides medical decisions in ways that fully respect the dignity of the person and the relationship with the health care professional.

Directives

23. The inherent dignity of the human person must be respected and protected regardless of the nature of the person's health problem or social status. The respect for human dignity extends to all persons who are served by Catholic health care.

24. In compliance with federal law, a Catholic health care institution will make available to patients information about their rights, under the laws of their state, to make an advance directive for their medical treatment. The institution, however, will not honor an advance directive that is contrary to Catholic teaching. If the advance directive conflicts with Catholic teaching, an explanation should be provided as to why the directive cannot be honored.

25. Each person may identify in advance a representative to make health care decisions as his or her surrogate in the event that the person loses the capacity to make health care decisions. Decisions by the designated surrogate should be faithful to Catholic moral principles and to the person's intentions and values, or if the person's intentions are unknown, to the person's best interests. In the event that an advance directive is not executed, those who are in a position to

know best the patient's wishes—usually family members and loved ones—should participate in the treatment decisions for the person who has lost the capacity to make health care decisions.

26. The free and informed consent of the person or the person's surrogate is required for medical treatments and procedures, except in an emergency situation when consent cannot be obtained and there is no indication that the patient would refuse consent to the treatment.

27. Free and informed consent requires that the person or the person's surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all.

28. Each person or the person's surrogate should have access to medical and moral information and counseling so as to be able to form his or her conscience. The free and informed health care decision of the person or the person's surrogate is to be followed so long as it does not contradict Catholic principles.

29. All persons served by Catholic health care have the right and duty to protect and preserve their bodily and functional integrity.¹⁶ The functional integrity of the person may be sacrificed to maintain the health or life of the person when no other morally permissible means is available.¹⁷

30. The transplantation of organs from living donors is morally permissible when such a donation will not sacrifice or seriously impair any essential bodily function and the anticipated benefit to the recipient is proportionate to the harm done to the donor. Furthermore, the freedom of the prospective donor must be respected, and economic advantages should not accrue to the donor.

31. No one should be the subject of medical or genetic experimentation, even if it is therapeutic, unless the person or surrogate first has given free and informed consent. In instances of nontherapeutic experimentation, the surrogate can give this consent only if the experiment entails no significant risk to the person's well-being. Moreover, the greater the person's incompetency and vulnerability, the greater the reasons must be to perform any medical experimentation, especially nontherapeutic.

32. While every person is obliged to use ordinary means to preserve his or her health, no person should be obliged to submit to a health care procedure that the person has judged, with a free and informed conscience, not to provide a reasonable hope of benefit without imposing excessive risks and burdens on the patient or excessive expense to family or community.¹⁸

33. The well-being of the whole person must be taken into account in deciding about any therapeutic intervention or use of technology. Therapeutic procedures that are likely to cause harm or undesirable side-effects can be justified only by a proportionate benefit to the patient.

34. Health care providers are to respect each person's privacy and confidentiality regarding information related to the person's diagnosis, treatment, and care.

35. Health care professionals should be educated to recognize the symptoms of abuse and violence and are obliged to report cases of abuse to the proper authorities in accordance with local statutes.

36. Compassionate and understanding care should be given to a person who is the victim of sexual assault. Health care providers should cooperate with law enforcement officials and offer the person psychological and spiritual support as well as accurate medical information. A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred

already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum.¹⁹

37. An ethics committee or some alternate form of ethical consultation should be available to assist by advising on particular ethical situations, by offering educational opportunities, and by reviewing and recommending policies. To these ends, there should be appropriate standards for medical ethical consultation within a particular diocese that will respect the diocesan bishop's pastoral responsibility as well as assist members of ethics committees to be familiar with Catholic medical ethics and, in particular, these Directives.

PART FOUR

Issues in Care for the Beginning of Life

Introduction

The Church's commitment to human dignity inspires an abiding concern for the sanctity of human life from its very beginning, and with the dignity of marriage and of the marriage act by which human life is transmitted. The Church cannot approve medical practices that undermine the biological, psychological, and moral bonds on which the strength of marriage and the family depends.

Catholic health care ministry witnesses to the sanctity of life "from the moment of conception until death."²⁰ The Church's defense of life encompasses the unborn and the care of women and their children during and after pregnancy. The Church's commitment to life is seen in its willingness to collaborate with others to alleviate the causes of the high infant mortality rate and to provide adequate health care to mothers and their children before and after birth.

The Church has the deepest respect for the family, for the marriage covenant, and for the love that binds a married couple together. This includes respect for the marriage act by which husband and wife express their love and cooperate with God in the creation of a new human being. The Second Vatican Council affirms:

This love is an eminently human one. . . . It involves the good of the whole person. . . . The actions within marriage by which the couple are united intimately and chastely are noble and worthy ones. Expressed in a manner which is truly

human, these actions signify and promote that mutual self-giving by which spouses enrich each other with a joyful and a thankful will.²¹

Marriage and conjugal love are by their nature ordained toward the begetting and educating of children. Children are really the supreme gift of marriage and contribute very substantially to the welfare of their parents. . . . Parents should regard as their proper mission the task of transmitting human life and educating those to whom it has been transmitted. . . . They are thereby cooperators with the love of God the Creator, and are, so to speak, the interpreters of that love.²²

For legitimate reasons of responsible parenthood, married couples may limit the number of their children by natural means. The Church cannot approve contraceptive interventions that “either in anticipation of the marital act, or in its accomplishment or in the development of its natural consequences, have the purpose, whether as an end or a means, to render procreation impossible.”²³ Such interventions violate “the inseparable connection, willed by God . . . between the two meanings of the conjugal act: the unitive and procreative meaning.”²⁴

With the advance of the biological and medical sciences, society has at its disposal new technologies for responding to the problem of infertility. While we rejoice in the potential for good inherent in many of these technologies, we cannot assume that what is technically possible is always morally right. Reproductive technologies that substitute for the marriage act are not consistent with human dignity. Just as the marriage act is joined naturally to procreation, so procreation is joined naturally to the marriage act. As Pope John XXIII observed:

The transmission of human life is entrusted by nature to a personal and conscious act and as such is subject to all the holy laws of God: the immutable and

inviolable laws which must be recognized and observed. For this reason, one cannot use means and follow methods which could be licit in the transmission of the life of plants and animals.²⁵

Because the moral law is rooted in the whole of human nature, human persons, through intelligent reflection on their own spiritual destiny, can discover and cooperate in the plan of the Creator.²⁶

Directives

38. When the marital act of sexual intercourse is not able to attain its procreative purpose, assistance that does not separate the unitive and procreative ends of the act, and does not substitute for the marital act itself, may be used to help married couples conceive.²⁷

39. Those techniques of assisted conception that respect the unitive and procreative meanings of sexual intercourse and do not involve the destruction of human embryos, or their deliberate generation in such numbers that it is clearly envisaged that all cannot implant and some are simply being used to maximize the chances of others implanting, may be used as therapies for infertility.

40. Heterologous fertilization (that is, any technique used to achieve conception by the use of gametes coming from at least one donor other than the spouses) is prohibited because it is contrary to the covenant of marriage, the unity of the spouses, and the dignity proper to parents and the child.²⁸

41. Homologous artificial fertilization (that is, any technique used to achieve conception using the gametes of the two spouses joined in marriage) is prohibited when it separates procreation from the marital act in its unitive significance (e.g., any technique used to achieve extracorporeal conception).²⁹

42. Because of the dignity of the child and of marriage, and because of the uniqueness of the mother-child relationship, participation in contracts or arrangements for surrogate motherhood is not permitted. Moreover, the commercialization of such surrogacy denigrates the dignity of women, especially the poor.³⁰

43. A Catholic health care institution that provides treatment for infertility should offer not only technical assistance to infertile couples but also should help couples pursue other solutions (e.g., counseling, adoption).

44. A Catholic health care institution should provide prenatal, obstetric, and postnatal services for mothers and their children in a manner consonant with its mission.

45. Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo. Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation. In this context, Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers.

46. Catholic health care providers should be ready to offer compassionate physical, psychological, moral, and spiritual care to those persons who have suffered from the trauma of abortion.

47. Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child.

48. In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion.³¹

49. For a proportionate reason, labor may be induced after the fetus is viable.

50. Prenatal diagnosis is permitted when the procedure does not threaten the life or physical integrity of the unborn child or the mother and does not subject them to disproportionate risks; when the diagnosis can provide information to guide preventative care for the mother or pre- or postnatal care for the child; and when the parents, or at least the mother, give free and informed consent. Prenatal diagnosis is not permitted when undertaken with the intention of aborting an unborn child with a serious defect.³²

51. Nontherapeutic experiments on a living embryo or fetus are not permitted, even with the consent of the parents. Therapeutic experiments are permitted for a proportionate reason with the free and informed consent of the parents or, if the father cannot be contacted, at least of the mother. Medical research that will not harm the life or physical integrity of an unborn child is permitted with parental consent.³³

52. Catholic health institutions may not promote or condone contraceptive practices but should provide, for married couples and the medical staff who counsel them, instruction both about the Church's teaching on responsible parenthood and in methods of natural family planning.

53. Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available.³⁴

54. Genetic counseling may be provided in order to promote responsible parenthood and to prepare for the proper treatment and care of children with genetic defects, in accordance with Catholic moral teaching and the intrinsic rights and obligations of married couples regarding the transmission of life.

PART FIVE

Issues in Care for the Seriously Ill and Dying

Introduction

Christ's redemption and saving grace embrace the whole person, especially in his or her illness, suffering, and death.³⁵ The Catholic health care ministry faces the reality of death with the confidence of faith. In the face of death—for many, a time when hope seems lost—the Church witnesses to her belief that God has created each person for eternal life.³⁶

Above all, as a witness to its faith, a Catholic health care institution will be a community of respect, love, and support to patients or residents and their families as they face the reality of death. What is hardest to face is the process of dying itself, especially the dependency, the helplessness, and the pain that so often accompany terminal illness. One of the primary purposes of medicine in caring for the dying is the relief of pain and the suffering caused by it. Effective management of pain in all its forms is critical in the appropriate care of the dying.

The truth that life is a precious gift from God has profound implications for the question of stewardship over human life. We are not the owners of our lives and, hence, do not have absolute power over life. We have a duty to preserve our life and to use it for the glory of God, but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome. Suicide and euthanasia are never morally acceptable options.

The task of medicine is to care even when it cannot cure. Physicians and their patients must evaluate the use of the technology at their disposal. Reflection on the innate dignity of human life in all its dimensions and on the purpose of medical care is indispensable for

formulating a true moral judgment about the use of technology to maintain life. The use of life-sustaining technology is judged in light of the Christian meaning of life, suffering, and death. In this way two extremes are avoided: on the one hand, an insistence on useless or burdensome technology even when a patient may legitimately wish to forgo it and, on the other hand, the withdrawal of technology with the intention of causing death.³⁷

The Church's teaching authority has addressed the moral issues concerning medically assisted nutrition and hydration. We are guided on this issue by Catholic teaching against euthanasia, which is "an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated."³⁸ While medically assisted nutrition and hydration are not morally obligatory in certain cases, these forms of basic care should in principle be provided to all patients who need them, including patients diagnosed as being in a "persistent vegetative state" (PVS), because even the most severely debilitated and helpless patient retains the full dignity of a human person and must receive ordinary and proportionate care.

Directives

55. Catholic health care institutions offering care to persons in danger of death from illness, accident, advanced age, or similar condition should provide them with appropriate opportunities to prepare for death. Persons in danger of death should be provided with whatever information is necessary to help them understand their condition and have the opportunity to discuss their condition with their family members and care providers. They should also be offered the appropriate medical information that would make it possible to address the morally legitimate choices available to them. They should be provided the spiritual support as well as the opportunity to receive the sacraments in order to prepare well for death.

56. A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community.³⁹

57. A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community.

58. In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the "persistent vegetative state") who can reasonably be expected to live indefinitely if given such care.⁴⁰ Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be "excessively burdensome for the patient or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed."⁴¹ For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort.

59. The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching.

60. Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way. Dying patients who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death.⁴²

61. Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die. Since a person has the right to prepare for his or her death while fully conscious, he or she should not be deprived of consciousness without a compelling reason. Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the intent is not to hasten death. Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering.

62. The determination of death should be made by the physician or competent medical authority in accordance with responsible and commonly accepted scientific criteria.

63. Catholic health care institutions should encourage and provide the means whereby those who wish to do so may arrange for the donation of their organs and bodily tissue, for ethically legitimate purposes, so that they may be used for donation and research after death.

64. Such organs should not be removed until it has been medically determined that the patient has died. In order to prevent any conflict of interest, the physician who determines death should not be a member of the transplant team.

65. The use of tissue or organs from an infant may be permitted after death has been determined and with the informed consent of the parents or guardians.

66. Catholic health care institutions should not make use of human tissue obtained by direct abortions even for research and therapeutic purposes.⁴³

PART SIX

Forming New Partnerships with Health Care Organizations and Providers

Introduction

Until recently, most health care providers enjoyed a degree of independence from one another. In ever-increasing ways, Catholic health care providers have become involved with other health care organizations and providers. For instance, many Catholic health care systems and institutions share in the joint purchase of technology and services with other local facilities or physicians' groups. Another phenomenon is the growing number of Catholic health care systems and institutions joining or co-sponsoring integrated delivery networks or managed care organizations in order to contract with insurers and other health care payers. In some instances, Catholic health care systems sponsor a health care plan or health maintenance organization. In many dioceses, new partnerships will result in a decrease in the number of health care providers, at times leaving the Catholic institution as the sole provider of health care services. At whatever level, new partnerships forge a variety of interwoven relationships: between the various institutional partners, between health care providers and the community, between physicians and health care services, and between health care services and payers.

On the one hand, new partnerships can be viewed as opportunities for Catholic health care institutions and services to witness to their religious and ethical commitments and so influence the healing profession. For example, new partnerships can help to implement the Church's social teaching. New partnerships can be opportunities to realign the local delivery system in order to provide a continuum of health care to the community; they can witness to a

responsible stewardship of limited health care resources; and they can be opportunities to provide to poor and vulnerable persons a more equitable access to basic care.

On the other hand, new partnerships can pose serious challenges to the viability of the identity of Catholic health care institutions and services, and their ability to implement these Directives in a consistent way, especially when partnerships are formed with those who do not share Catholic moral principles. The risk of scandal cannot be underestimated when partnerships are not built upon common values and moral principles. Partnership opportunities for some Catholic health care providers may even threaten the continued existence of other Catholic institutions and services, particularly when partnerships are driven by financial considerations alone. Because of the potential dangers involved in the new partnerships that are emerging, an increased collaboration among Catholic-sponsored health care institutions is essential and should be sought before other forms of partnerships.

The significant challenges that new partnerships may pose, however, do not necessarily preclude their possibility on moral grounds. The potential dangers require that new partnerships undergo systematic and objective moral analysis, which takes into account the various factors that often pressure institutions and services into new partnerships that can diminish the autonomy and ministry of the Catholic partner. The following directives are offered to assist institutionally based Catholic health care services in this process of analysis. To this end, the United States Conference of Catholic Bishops (formerly the National Conference of Catholic Bishops) has established the Ad Hoc Committee on Health Care Issues and the Church as a resource for bishops and health care leaders.

This new edition of the *Ethical and Religious Directives* omits the appendix concerning cooperation, which was contained in the 1995 edition. Experience has shown that the brief

articulation of the principles of cooperation that was presented there did not sufficiently forestall certain possible misinterpretations and in practice gave rise to problems in concrete applications of the principles. Reliable theological experts should be consulted in interpreting and applying the principles governing cooperation, with the proviso that, as a rule, Catholic partners should avoid entering into partnerships that would involve them in cooperation with the wrongdoing of other providers.

Directives

67. Decisions that may lead to serious consequences for the identity or reputation of Catholic health care services, or entail the high risk of scandal, should be made in consultation with the diocesan bishop or his health care liaison.

68. Any partnership that will affect the mission or religious and ethical identity of Catholic health care institutional services must respect church teaching and discipline. Diocesan bishops and other church authorities should be involved as such partnerships are developed, and the diocesan bishop should give the appropriate authorization before they are completed. The diocesan bishop's approval is required for partnerships sponsored by institutions subject to his governing authority; for partnerships sponsored by religious institutes of pontifical right, his *nihil obstat* should be obtained.

69. If a Catholic health care organization is considering entering into an arrangement with another organization that may be involved in activities judged morally wrong by the Church, participation in such activities must be limited to what is in accord with the moral principles governing cooperation.

70. Catholic health care organizations are not permitted to engage in immediate material cooperation in actions that are intrinsically immoral, such as abortion, euthanasia, assisted suicide, and direct sterilization.⁴⁴

71. The possibility of scandal must be considered when applying the principles governing cooperation.⁴⁵ Cooperation, which in all other respects is morally licit, may need to be refused because of the scandal that might be caused. Scandal can sometimes be avoided by an appropriate explanation of what is in fact being done at the health care facility under Catholic auspices. The diocesan bishop has final responsibility for assessing and addressing issues of scandal, considering not only the circumstances in his local diocese but also the regional and national implications of his decision.⁴⁶

72. The Catholic partner in an arrangement has the responsibility periodically to assess whether the binding agreement is being observed and implemented in a way that is consistent with Catholic teaching.

CONCLUSION

Sickness speaks to us of our limitations and human frailty. It can take the form of infirmity resulting from the simple passing of years or injury from the exuberance of youthful energy. It can be temporary or chronic, debilitating, and even terminal. Yet the follower of Jesus faces illness and the consequences of the human condition aware that our Lord always shows compassion toward the infirm.

Jesus not only taught his disciples to be compassionate, but he also told them who should be the special object of their compassion. The parable of the feast with its humble guests was preceded by the instruction: “When you hold a banquet, invite the poor, the crippled, the lame, the blind” (Lk 14:13). These were people whom Jesus healed and loved.

Catholic health care is a response to the challenge of Jesus to go and do likewise. Catholic health care services rejoice in the challenge to be Christ’s healing compassion in the world and see their ministry not only as an effort to restore and preserve health but also as a spiritual service and a sign of that final healing that will one day bring about the new creation that is the ultimate fruit of Jesus’ ministry and God’s love for us.

Notes

1. United States Conference of Catholic Bishops, *Health and Health Care: A Pastoral Letter of the American Catholic Bishops* (Washington, DC: United States Conference of Catholic Bishops, 1981).
2. Health care services under Catholic auspices are carried out in a variety of institutional settings (e.g., hospitals, clinics, outpatient facilities, urgent care centers, hospices, nursing homes, and parishes). Depending on the context, these Directives will employ the terms “institution” and/or “services” in order to encompass the variety of settings in which Catholic health care is provided.
3. *Health and Health Care*, p. 5.
4. Second Vatican Ecumenical Council, *Decree on the Apostolate of the Laity (Apostolicam Actuositatem)* (1965), no. 1.
5. Pope John Paul II, Post-Synodal Apostolic Exhortation *On the Vocation and the Mission of the Lay Faithful in the Church and in the World (Christifideles Laici)* (Washington, DC: United States Conference of Catholic Bishops, 1988), no. 29.
6. As examples, see Congregation for the Doctrine of the Faith, *Declaration on Procured Abortion* (1974); Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (1980); Congregation for the Doctrine of the Faith, *Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation: Replies to Certain Questions of the Day (Donum Vitae)* (Washington, DC: United States Conference of Catholic Bishops, 1987).
7. Pope John XXIII, Encyclical Letter *Peace on Earth (Pacem in Terris)* (Washington, DC: United States Conference of Catholic Bishops, 1963), no. 11; *Health and Health Care*, pp. 5, 17-18; *Catechism of the Catholic Church*, 2nd ed. (Washington, DC: Libreria Editrice Vaticana– United States Conference of Catholic Bishops, 2000), no. 2211.
8. Pope John Paul II, *On Social Concern, Encyclical Letter on the Occasion of the Twentieth Anniversary of “Populorum Progressio” (Sollicitudo Rei Socialis)* (Washington, DC: United States Conference of Catholic Bishops, 1988), no. 43.
9. United States Conference of Catholic Bishops, *Economic Justice for All: Pastoral Letter on Catholic Social Teaching and the U.S. Economy* (Washington, DC: United States Conference of Catholic Bishops, 1986), no. 80.

10. The duty of responsible stewardship demands responsible collaboration. But in collaborative efforts, Catholic institutionally based health care services must be attentive to occasions when the policies and practices of other institutions are not compatible with the Church's authoritative moral teaching. At such times, Catholic health care institutions should determine whether or to what degree collaboration would be morally permissible. To make that judgment, the governing boards of Catholic institutions should adhere to the moral principles on cooperation. See Part Six.

11. *Health and Health Care*, p. 12.

12. Cf. *Code of Canon Law*, cc. 921-923.

13. Cf. *ibid.*, c. 867, § 2, and c. 871.

14. To confer Baptism in an emergency, one must have the proper intention (to do what the Church intends by Baptism) and pour water on the head of the person to be baptized, meanwhile pronouncing the words: "I baptize you in the name of the Father, and of the Son, and of the Holy Spirit."

15. Cf. c. 883, 3°.

16. For example, while the donation of a kidney represents loss of biological integrity, such a donation does not compromise functional integrity since human beings are capable of functioning with only one kidney.

17. Cf. directive 53.

18. *Declaration on Euthanasia*, Part IV; cf. also directives 56-57.

19. It is recommended that a sexually assaulted woman be advised of the ethical restrictions that prevent Catholic hospitals from using abortifacient procedures; cf. Pennsylvania Catholic Conference, "Guidelines for Catholic Hospitals Treating Victims of Sexual Assault," *Origins* 22 (1993): 810.

20. Pope John Paul II, "Address of October 29, 1983, to the 35th General Assembly of the World Medical Association," *Acta Apostolicae Sedis* 76 (1984): 390.

21. Second Vatican Ecumenical Council, *Pastoral Constitution on the Church in the Modern World* (*Gaudium et Spes*) (1965), no. 49.

22. *Ibid.*, no. 50.

23. Pope Paul VI, Encyclical Letter *On the Regulation of Birth (Humanae Vitae)* (Washington, DC: United States Conference of Catholic Bishops, 1968), no. 14.

24. *Ibid.*, no. 12.

25. Pope John XXIII, Encyclical Letter *Mater et Magistra* (1961), no. 193, quoted in Congregation for the Doctrine of the Faith, *Donum Vitae*, no. 4.

26. Pope John Paul II, Encyclical Letter *The Splendor of Truth* (*Veritatis Splendor*) (Washington, DC: United States Conference of Catholic Bishops, 1993), no. 50.

27. “Homologous artificial insemination within marriage cannot be admitted except for those cases in which the technical means is not a substitute for the conjugal act but serves to facilitate and to help so that the act attains its natural purpose” (*Donum Vitae*, Part II, B, no. 6; cf. also Part I, nos. 1, 6).

28. *Ibid.*, Part II, A, no. 2.

29. “Artificial insemination as a substitute for the conjugal act is prohibited by reason of the voluntarily achieved dissociation of the two meanings of the conjugal act. Masturbation, through which the sperm is normally obtained, is another sign of this dissociation: even when it is done for the purpose of procreation, the act remains deprived of its unitive meaning: ‘It lacks the sexual relationship called for by the moral order, namely, the relationship which realizes “the full sense of mutual self-giving and human procreation in the context of true love”’” (*Donum Vitae*, Part II, B, no. 6).

30. *Ibid.*, Part II, A, no. 3.

31. Cf. directive 45.

32. *Donum Vitae*, Part I, no. 2.

33. Cf. *ibid.*, no. 4. (Washington, DC: United States Conference of Catholic Bishops, 1988), no. 43.

34. Cf. Congregation for the Doctrine of the Faith, “Responses on Uterine Isolation and Related Matters,” July 31, 1993, *Origins* 24 (1994): 211-212.

35. Pope John Paul II, Apostolic Letter *On the Christian Meaning of Human Suffering* (*Salvifici Doloris*) (Washington, DC: United States Conference of Catholic Bishops, 1984), nos. 25-27.

36. United States Conference of Catholic Bishops, *Order of Christian Funerals* (Collegeville, Minn.: The Liturgical Press, 1989), no. 1.

37. See *Declaration on Euthanasia*.

38. *Ibid.*, Part II.

39. *Ibid.*, Part IV; Pope John Paul II, Encyclical Letter *On the Value and Inviolability of Human Life* (*Evangelium Vitae*) (Washington, DC: United States Conference of Catholic Bishops, 1995), no. 65.

40. See Pope John Paul II, Address to the Participants in the International Congress on “Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas” (March 20, 2004), no. 4, where he emphasized that “the administration of water and food, even when provided by artificial means, always represents a *natural means* of preserving life, not a *medical act*.” See also Congregation for the Doctrine of the Faith, “Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration” (August 1, 2007).

41. Congregation for the Doctrine of the Faith, Commentary on “Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration.”

42. See *Declaration on Euthanasia*, Part IV.

43. *Donum Vitae*, Part I, no. 4.

44. While there are many acts of varying moral gravity that can be identified as intrinsically evil, in the context of contemporary health care the most pressing concerns are currently abortion, euthanasia, assisted suicide, and direct sterilization. See Pope John Paul II’s *Ad Limina* Address to the bishops of Texas, Oklahoma, and Arkansas (Region X), in *Origins* 28 (1998): 283. See also “Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilization in Catholic Hospitals” (*Quaecumque Sterilizatio*), March 13, 1975, *Origins* 6 (1976): 33-35: “Any cooperation institutionally approved or tolerated in actions which are in themselves, that is, by their nature and condition, directed to a contraceptive end . . . is absolutely forbidden. For the official approbation of direct sterilization and, *a fortiori*, its management and execution in accord with hospital regulations, is a matter which, in the objective order, is by its very nature (or intrinsically) evil.” This directive supersedes the “Commentary on the Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilization in Catholic Hospitals” published by the National Conference of Catholic Bishops on September 15, 1977, in *Origins* 7 (1977): 399-400.

45. See *Catechism of the Catholic Church*: “Scandal is an attitude or behavior which leads another to do evil” (no. 2284); “Anyone who uses the power at his disposal in such a way that it leads others to do wrong becomes guilty of scandal and responsible for the evil that he has directly or indirectly encouraged” (no. 2287).

46. See “The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry,” *Origins* 26 (1997): 703.

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General Secretary, USCCB

In 2001 the National Conference of Catholic Bishops and United States Catholic Conference became the United States Conference of Catholic Bishops.

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