

1 Jeffrey T. Sprung, WSBA #23607
 Martha Rodríguez López, WSBA #35466
 2 Zachary P. Jones, WSBA #44557
 Jeffrey C. Grant, WSBA #11046
 3 R. July Simpson, WSBA #45869
Assistant Attorneys General
 4 ROBERT W. FERGUSON
 ATTORNEY GENERAL
 5 Washington Attorney General’s Office
 800 Fifth Avenue, Suite 2000
 6 Seattle, WA 98104
 (206) 464-7744

7
 8 **UNITED STATES DISTRICT COURT**
EASTERN DISTRICT OF WASHINGTON
 9 **AT SPOKANE**

10 STATE OF WASHINGTON,

NO. 2:19-cv-00183

11 Plaintiff,

COMPLAINT FOR
 DECLARATORY AND
 INJUNCTIVE RELIEF

12 v.

13 ALEX M. AZAR II, in his official
 capacity as Secretary of the United
 States Department of Health and
 Human Services; and UNITED
 14 STATES DEPARTMENT OF
 15 HEALTH AND HUMAN
 SERVICES,

16 Defendants.
 17

TABLE OF CONTENTS

1

2 I. INTRODUCTION..... 1

3 II. PARTIES 4

4 III. JURISDICTION AND VENUE..... 5

5 IV. RELEVANT FACTS..... 6

6 A. Federal Statutory and Regulatory Background..... 6

7 1. Federal laws that protect patients and assure access to

8 modern health care..... 6

9 a. The Patient Protection and Affordable Care Act’s

10 contraceptive coverage requirement..... 6

11 b. The Emergency Medical Treatment and Labor Act..... 7

12 c. The mandate for non-directive pregnancy counseling in

13 the appropriations acts applicable to the Title X family

14 planning program 8

15 d. The ACA bars HHS regulations that deny patients timely

16 access to medical care, interfere with provider-patient

17 communications, or undermine informed consent or

18 medical ethics 10

19 2. Federal refusal laws that protect conscience-based objections

20 to providing certain health care services 12

21 a. The Church Amendments..... 12

22 b. The Coats-Snowe Amendment..... 13

c. The Weldon Amendment 13

d. Refusal rights in the ACA 14

e. Other federal statutory refusal rights..... 14

1 B. Washington Laws Guaranteeing Timely Access to Health Care
and Respecting Conscience-Based Refusal Rights..... 15

2 1. Washington’s statutory conscience protection statute..... 15

3 2. The Reproductive Privacy Act, Wash. Rev. Code 9.02.100,
4 *et seq.* 17

5 3. The Reproductive Parity Act, Wash. Rev. Code 48.43.072–
6 .073..... 18

7 4. Informed consent, Wash. Rev. Code 7.70.050–.060 21

8 5. Regulation of pharmacies’ responsibilities, Wash. Admin
Code 246-869-010 24

9 6. Washington Charity Care Law, Wash. Rev. Code
10 70.170.060 26

11 7. Emergency contraception for sexual assault victims, Wash.
Rev. Code 70.41.350 27

12 8. Duty to comply with advanced directives, Wash. Rev. Code
13 70.122.030 27

14 9. Information concerning end-of-life care options, Wash. Rev.
Code 70.245 28

15 10. Services for LGBTQ individuals 30

16 11. Patient abandonment..... 31

17 C. HHS’s 2019 Final Rule 33

18 1. Background..... 33

19 2. Definitions section 35

20 a. “Assist in the performance” 35

21 b. “Discriminate” or “discrimination” 37

22 c. “Entity” and “health care entity” 38

1 d. “Health service program” 39
2 e. “Referral” or “refer for” 40
3 3. Assurance and certification..... 40
4 4. Compliance and enforcement 40
5 5. Preemption 41
6 D. The Final Rule’s Impact on Washington 42
7 1. Abrogation of Washington’s laws protecting patients 42
8 2. Denied or delayed health care to Washingtonians 43
9 3. Impact on state health care institutions..... 45
10 4. Financial injury to Washington 46
11 V. CLAIMS FOR RELIEF 49
12 VI. PRAYER FOR RELIEF 58
13
14
15
16
17
18
19
20
21
22

I. INTRODUCTION

1
2 1. The State of Washington seeks to enjoin and set aside the U.S.
3 Department of Health and Human Service’s (HHS) May 21, 2019 Final Rule,¹
4 which imposes the religious views of officials at HHS on Washingtonians and
5 individuals across the country who seek timely, medically necessary care and
6 information about reproductive health, LGBTQ health, and end-of-life care.
7 Echoing these views, at a Rose Garden ceremony touting the release of the rule,
8 President Trump said: “Together we are building a culture that cherishes the
9 dignity and worth of human life. Every child, born and unborn is a sacred gift
10 from God.”²

11 2. Washington law reflects a long tradition of respecting the religious
12 beliefs of its citizens. At the same time, its laws have struck a balance so that no
13 one’s religious views are imposed unwillingly on another. Therefore,
14 Washington’s laws require that no health care provider’s conscience-based
15 refusal results in the denial of timely access to information and services required
16 by prevailing medical and ethical standards.

17
18
19 ¹ *Protecting Statutory Conscience Rights in Health Care; Delegations of*
20 *Authority*, 84 Fed. Reg. 23170 (May 21, 2019) (Final Rule), *see infra* at 33 n.6.

21 ² [https://www.whitehouse.gov/briefings-statements/remarks-president-](https://www.whitehouse.gov/briefings-statements/remarks-president-trump-national-day-prayer-service/)
22 [trump-national-day-prayer-service/](https://www.whitehouse.gov/briefings-statements/remarks-president-trump-national-day-prayer-service/), *see infra* at 33 n.5.

1 3. The Final Rule tramples Washington’s careful balance of rights and
2 interests. Instead, it imposes its absolute position on the State, its health care
3 institutions, and its residents. In the Final Rule, HHS misinterprets several federal
4 statutes to create a categorical, absolute right by health care providers or their
5 employees to deny medical information and care solely on the basis of their
6 religious or moral tenets, even when required by the corresponding medical
7 standard of care. HHS’s expansive new refusal right applies to *any* employee of
8 a covered institution and extends its protections to non-health care providers like
9 insurers and employers.

10 4. HHS assumes the power to impose its religious values on the most
11 sensitive health decisions and relationships, purporting to preempt longstanding
12 Washington laws protecting patients’ rights. Under the Final Rule, an emergency
13 room may refuse to provide emergency contraception to a victim of a violent
14 sexual assault. An institution at which a pregnant women discovers that her fetus
15 is anencephalic—developing without the major structures of the brain—may
16 refuse counseling on all medically indicated options. A religious provider treating
17 a patient suffering from a painful, terminal illness who desires to use the
18 Washington Death With Dignity Act may refuse to transfer medical records to a
19 non-objecting provider. A hospital scheduler or a health insurer’s telephone
20 representative could assert a moral objection to assisting gay or transgender
21 individuals seeking medical care.

22

1 5. HHS’s legal interpretation violates numerous statutory limits on its
2 authority. In the Patient Protection and Affordable Care Act, the Emergency
3 Medical Treatment and Labor Act, and annual appropriations acts for the Title X
4 family planning program, Congress created national standards for certain health
5 care and health insurance coverage. The Final Rule disregards those standards.
6 Further, in a section of the ACA addressing HHS’s rulemaking authority,
7 Congress barred HHS from adopting regulations that impede access to health care
8 information or services, violate principles of informed consent, or undercut the
9 ethical standards of health care professionals. The Final Rule oversteps all of
10 these restrictions. And HHS interprets the statutory provisions that are the subject
11 of the Final Rule so broadly as to defy Congress’s clear intent, assertedly
12 preempting state laws on the books for decades.

13 6. Furthermore, in violation of statutory and constitutional limits, HHS
14 attempts to coerce Washington’s compliance with the Final Rule by subjecting it
15 to the risk of the loss of *all* federal health care funds—over \$10 billion per year—
16 if the State, its health care institutions, or its subrecipients violate the Final Rule.
17 The Final Rule puts Washington to the Hobson’s choice between enforcing its
18 patient protection and civil rights laws and jeopardizing the federal funds that
19 supports its Medicaid and children’s health insurance programs.

20 7. In placing its thumb on the scales to favor religious views at the
21 expense of patients’ guaranteed access to timely and complete health information
22

1 and care, HHS harms the most vulnerable Washingtonians. In rural areas in
2 eastern Washington, patients seeking urgent reproductive care, end-of-life
3 assistance, or gender-affirming surgery or treatment may be forced to travel
4 hundreds of miles for care. By imposing an absolute duty on health care providers
5 to accommodate the religious objections of any employee to providing *any*
6 service to *any* patient, the Final Rule invites and sanctions discrimination against
7 patients based on their sexual orientation or gender identity. Affluent patients will
8 nevertheless access care that is consistent with principles of informed consent,
9 but many rural patients and the working poor will be hostage to the particular
10 religious views of their health care providers.

11 8. The Administrative Procedure Act (APA), 5 U.S.C. § 706(2),
12 empowers the Court to enjoin and set aside agency action that is contrary to
13 constitutional right or in excess of statutory authority, or is arbitrary, capricious,
14 an abuse of discretion, or otherwise not in accordance with law. To avert
15 irreparable injury to the State and its residents, Washington brings this suit to
16 declare unlawful and enjoin the Final Rule.

17 II. PARTIES

18 9. Plaintiff the State of Washington is represented by its Attorney
19 General, who is the State's chief legal adviser. The powers and duties of the
20 Attorney General include acting in federal court on matters of public concern to
21 the State.
22

1 15. Defendants' publication of the Final Rule in the Federal Register on
2 May 21, 2019, constitutes a final agency action and is therefore judicially
3 reviewable within the meaning of the APA. 5 U.S.C. §§ 704, 706.

4 16. Venue is proper in this Court pursuant to 28 U.S.C. § 1391(e)
5 because this is a judicial district in which the State of Washington resides and
6 this action seeks relief against federal agencies and officials acting in their official
7 capacities. *See California v. Azar*, 911 F.3d 558, 569–70 (9th Cir. 2018).

8 IV. RELEVANT FACTS

9 A. Federal Statutory and Regulatory Background

10 17. Congress has enacted into law both affirmative requirements to
11 ensure Americans' access to modern and effective health care and conscience
12 protections for health care providers who refuse to perform certain services.

13 1. Federal laws that protect patients and assure access to modern 14 health care

15 a. The Patient Protection and Affordable Care Act's 16 contraceptive coverage requirement

17 18. In 2010, Congress enacted the Patient Protection and Affordable
18 Care Act (Pub. L. No. 111-148) and the Health Care and Education
19 Reconciliation Act of 2010 (Pub. L. No. 111-152) (collectively, the ACA). The
20 ACA imposes an obligation on insurers to provide contraceptive coverage.
21 42 U.S.C. § 300gg-13(a)(4).
22

1 19. A limited exemption from the contraceptive coverage mandate
2 exists for religious employers (defined as “churches, their integrated auxiliaries,
3 and conventions or associations of churches,” and “the exclusively religious
4 activities of any religious order” that are organized and operate as nonprofit
5 entities). In addition, for certain non-exempt employers with religious beliefs that
6 conflict with the use of contraceptives, federal law contains an accommodation.
7 This accommodation is intended to ensure, in the words of the Supreme Court,
8 that eligible non-church organizations can follow “an approach going forward
9 that accommodates [their] religious exercise while at the same time *ensuring that*
10 *women covered by [their] health plans ‘receive full and equal health coverage,*
11 *including contraceptive coverage.’ ” *Zubik v. Burwell*, 136 S. Ct. 1557, 1559*
12 (2016) (per curiam) (emphasis added).

13 20. Eight courts of appeals have concluded that requiring religious
14 objectors to notify the government of their objection to providing contraceptive
15 coverage, so that the government can ensure that the responsible insurer or
16 third-party administrator steps in to meet the ACA’s requirements, does not
17 impose a substantial burden on religious exercise.

18 **b. The Emergency Medical Treatment and Labor Act**

19 21. In 1986, Congress enacted the Emergency Medical Treatment and
20 Labor Act (EMTALA) to ensure public access to emergency services regardless
21 of a patient’s ability to pay. 42 U.S.C. § 1395dd.

22

1 22. Under EMTALA, a hospital must provide patients with a medical
2 screening examination and, if the patient has an “emergency medical condition,”
3 provide stabilizing treatment or execute an appropriate transfer. 42 U.S.C.
4 § 1395dd; 42 C.F.R § 489.24. The term “emergency medical condition” includes
5 “a medical condition manifesting itself by acute symptoms of sufficient severity
6 (including severe pain) such that the absence of immediate medical attention
7 could reasonably be expected to result in placing the health of the individual (or,
8 with respect to a pregnant woman, the health of the woman or her unborn child)
9 in serious jeopardy” 42 U.S.C. § 1395dd(e)(1).

10 23. Hospitals and physicians violating EMTALA are subject to civil
11 monetary penalties and the threat of Medicare decertification. 42 U.S.C.
12 § 1395dd(d).

13 **c. The mandate for non-directive pregnancy counseling in**
14 **the appropriations acts applicable to the Title X family**
15 **planning program**

16 24. In 1970, Congress enacted the Family Planning Services and
17 Population Research Act of 1970, 42 U.S.C. § 300, *et seq.*, which added Title X
18 to the Public Health Service Act. Title X seeks to help low-income women reduce
19 their rate of unintended pregnancies and exercise control over their economic
20 lives and health by offering federally-funded access to effective contraception
21 and reproductive health care. The statute requires the HHS Secretary to award
22 grants to state or local governments and non-profit organizations for the

1 “establishment and operation of voluntary family planning projects” to provide
2 contraception and other reproductive health care, with priority given to persons
3 from low-income households. 42 U.S.C. §§ 300(a), 300(b), 300a-4(c)(1).

4 25. Since 1996, Congress has passed annual appropriations acts
5 applicable to HHS requiring that all pregnancy counseling within a Title X
6 program *must* be nondirective.³ Under this non-directive mandate, all recipients
7 of Title X grant funds must ensure that patients determined to be pregnant receive
8 “information on all available options without promoting, advocating, or
9 encouraging one option over another.” 83 Fed. Reg. 25512, n.41 (Jun. 1, 2018).

10
11 _____
12 ³ See Pub. L. No. 115-245 (Sept. 28, 2018); Pub. L. No. 115-141 (Mar. 23,
13 2018); Pub. L. No. 115-31 (May 5, 2017); Pub. L. No. 114-113 (Dec. 18, 2015);
14 Pub. L. No. 113-76 (Jan. 17, 2014); Pub. L. No. 113-235 (Dec. 16, 2014); Pub.
15 L. No. 112-74 (Dec. 23, 2011); Pub. L. No. 111-117 (Dec. 16, 2009); Pub. L. No.
16 111-8 (Mar. 11, 2009); Pub. L. No. 111-322 (Dec. 22, 2010); Pub. L. No. 110-161
17 (Dec. 26, 2007); Pub. L. No. 109-149 (Dec. 30, 2005); Pub. L. No. 108-199
18 (Jan. 23, 2004); Pub. L. No. 108-7 (Feb. 20, 2003); Pub. L. No. 108-447 (Dec. 8,
19 2004); Pub. L. No. 107-116 (Jan. 10, 2002); Pub. L. No. 106-554 (Dec. 21, 2000);
20 Pub. L. No. 106-113 (Nov. 29, 1999); Pub. L. No. 105-78 (Nov. 13, 1997); Pub.
21 L. No. 105-277 (Oct. 21, 1998); Pub. L. No. 104-134 (Apr. 26, 1996); Pub. L.
22 No. 104-208 (Sept. 30, 1996).

1 26. Congress’s non-directive mandate requires that pregnant Title X
 2 patients receive information on abortion upon request. HHS explicitly adopted
 3 recommendations made by the American College of Obstetricians and
 4 Gynecologists and the American Academy of Pediatrics stating that “[i]f the
 5 patient indicates that the pregnancy is unwanted, she should be fully informed in
 6 a balanced manner about all options, including raising the child herself, placing
 7 the child for adoption, and abortion.” American Academy of Pediatrics & The
 8 American College of Obstetricians & Gynecologists (ACOG), Guidelines for
 9 Perinatal Care, p. 127 (7th ed. 2016).⁴ Congress did not create a conscience-based
 10 right for the voluntary applicants for Title X grants to refuse to comply with the
 11 non-directive mandate.

12 **d. The ACA bars HHS regulations that deny patients**
 13 **timely access to medical care, interfere with**
 14 **provider-patient communications, or undermine**
 informed consent or medical ethics

15 27. In passing the ACA in 2010, Congress enacted a statutory section
 16 that preserves the sanctity and integrity of the patient-provider relationship by
 17 prohibiting interference by federal regulators. Section 1554 bars HHS from

18
 19 ⁴ See *Providing Quality Family Planning Services: Recommendations of*
 20 *CDC and the U.S. Office of Population Affairs*, Morbidity and Mortality Weekly
 21 Report Vol. 63, No. 4 (April 25, 2014), available at [https://www.cdc.gov](https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf)
 22 [/mmwr/pdf/rr/rr6304.pdf](https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf) (last accessed January 2, 2019).

1 adopting any regulations that impede patients’ access to medical information and
2 quality care. Section 1554 provides that the Secretary of HHS “shall not
3 promulgate any regulation” that, *inter alia*:

- 4 1. creates any unreasonable barriers to the ability of individuals
5 to obtain appropriate medical care;
- 6 2. impedes timely access to health care services;
- 7 3. interferes with communications regarding a full range of
8 treatment options between the patient and the provider;
- 9 4. restricts the ability of health care providers to provide full
10 disclosure of all relevant information to patients making
11 health care decisions; or
- 12 5. violates the principles of informed consent and the ethical
13 standards of health care professionals.

14 42 U.S.C. § 18114.

15 28. In addition to federal health care laws that balance conscience rights
16 with Americans’ right to timely and modern health care, federal civil rights laws
17 balance the protection of religious beliefs against employers’ needs to manage
18 their business affairs. Title VII of the Civil Rights Act of 1964 prohibits
19 discrimination in employment based on religious beliefs. 42 U.S.C. § 2000e-2(a).
20 It also provides that employers are not obligated to accommodate employees’
21 religious beliefs where they would cause “undue hardship” on the employer’s
22 business. 42 U.S.C. § 2000e(j). Freedom of religion “gives no one the right to
insist that in pursuit of their own interests others must conform their conduct to

1 his own religious necessities.” *Otten v. Baltimore & O.R. Co.*, 205 F.2d 58, 61
2 (2d Cir. 1953).

3 29. HHS expressly declined to incorporate an assessment of undue
4 burden on employers in its categorical protection of conscience rights. 84 Fed.
5 Reg. 23191 (May 21, 2019). The Final Rule fails to address how HHS will
6 determine if Washington’s health care institutions engaged in “discrimination”
7 where an employee’s absolute right to refuse information and care on conscience
8 grounds conflicts with Title VII’s balancing test.

9 **2. Federal refusal laws that protect conscience-based objections**
10 **to providing certain health care services**

11 **a. The Church Amendments**

12 30. Under the Church Amendments, entities that receive certain federal
13 funds cannot require that individuals perform or assist in performing any
14 sterilization procedure, abortion, or other health care programs or research if
15 doing so would be contrary to religious beliefs or moral convictions. Entities
16 cannot be required to make their facilities available for any sterilization
17 procedure or abortion if the procedure is prohibited based on the entity’s religious
18 beliefs or moral convictions.

19 31. Entities that receive certain federal funds (including those who
20 receive HHS grants or contracts for biomedical or behavioral research) cannot
21 discriminate in employment, promotion, termination, or the extension of staff or
22 other privileges because a provider performed or assisted in the performance of

1 a lawful sterilization procedure or abortion—or refused to do so based on
2 religious beliefs or moral convictions.

3 32. There are similar protections for those who apply to health care
4 training or study programs, including internships and residencies. Individuals
5 cannot be denied admission or discriminated against based on their willingness
6 or unwillingness to counsel, suggest, recommend, assist, or participate in
7 performing an abortion or sterilization if doing so is contrary to their religious
8 beliefs or moral convictions.

9 **b. The Coats-Snowe Amendment**

10 33. The Coats-Snowe Amendment prohibits government entities that
11 receive federal financial assistance from discriminating against health care
12 entities (including physicians and those in health professional training programs)
13 that refuse to undergo training to perform abortions, refuse to provide referrals
14 for abortions or abortion training, or refuse to make arrangements for those
15 activities. Discrimination could occur if, for instance, the government denied an
16 entity a license to operate or refused financial assistance, services, or other
17 benefits. This amendment also applies to the accreditation of postgraduate
18 physician training programs.

19 **c. The Weldon Amendment**

20 34. The Weldon Amendment has been included in annual
21 appropriations acts since 2004 and restricts the use of federal funds provided
22

1 through the Departments of Labor and HHS appropriations bill. The Weldon
2 Amendment prohibits government entities from using these funds to discriminate
3 against health care entities because they do not provide, pay for, cover, or refer
4 for abortions. There are similar appropriations laws that prohibit HHS from
5 barring a provider-sponsored organization from participating in Medicare
6 Advantage because it will not provide, pay for, cover, or refer for abortions.

7 **d. Refusal rights in the ACA**

8 35. The ACA included a number of health care conscience provisions.
9 Under Section 1303, health plans are not required to cover abortion services as
10 part of the essential health benefits package and cannot discriminate against
11 providers or facilities because of their unwillingness to provide, pay for, cover,
12 or refer for abortions. The individual mandate includes a religious conscience
13 exemption for members of a health care sharing ministry and organizations or
14 individuals that oppose insurance benefits for religious reasons. Section 1553 of
15 the ACA prohibits government entities that receive federal financial assistance
16 under the ACA from discriminating against an individual or health care entity
17 because of an objection to providing items or service related to assisted suicide.

18 **e. Other federal statutory refusal rights**

19 36. Other federal health care conscience laws prohibit Medicare and
20 Medicaid providers, organizations, or employees—including hospitals, skilled
21 nursing facilities, hospice programs, Medicaid managed care organizations, and
22

1 Medicare Advantage plans—from being required to inform or counsel an
2 individual about a right to an item or service related to assisted suicide or advance
3 directives. Medicare Advantage plans and Medicaid managed care organizations
4 cannot be compelled to provide, reimburse for, or cover counseling or referrals
5 that they object to on moral or religious grounds.

6 **B. Washington Laws Guaranteeing Timely Access to Health Care and**
7 **Respecting Conscience-Based Refusal Rights**

8 **1. Washington’s statutory conscience protection statute**

9 37. Washington’s legislature has crafted a careful balance between
10 individuals’ religious and moral beliefs and patients’ rights to health care.

11 38. Washington law states:

12 The legislature recognizes that every individual possesses a
13 fundamental right to exercise their religious beliefs and conscience.
14 The legislature further recognizes that in developing public policy,
15 conflicting religious and moral beliefs must be respected. Therefore,
16 while recognizing the right of conscientious objection to
17 participating in specific health services, the state shall also recognize
18 the right of individuals enrolled with plans containing the basic
19 health plan services to receive the full range of services covered
20 under the plan.

21 Wash. Rev. Code 48.43.065; *see also* Wash. Rev. Code 70.47.160.

22 39. Consistent with this legislative goal, the conscience protection
statute clarifies that “[n]o individual health care provider, religiously sponsored
health carrier, or health care facility may be required by law or contract in any
circumstances to participate in the provision of or payment for a specific service
if they object to so doing for reason of conscience or religion.” Wash. Rev. Code

1 48.43.065(2)(a). Nor are individuals or organizations with a religious or moral
2 tenet “required to purchase [insurance] coverage for that service or services if
3 they object to doing so for reason of conscience or religion.” Wash. Rev. Code
4 48.43.065(2)(b); *see also* Wash. Rev. Code 70.47.160(2)(b). The statute also
5 protects persons from discrimination “in employment or professional privileges”
6 because they assert a conscience objection. Wash. Rev. Code 48.43.065(2)(a);
7 *see also* Wash. Rev. Code 70.47.160(2)(a).

8 40. While recognizing the right of conscientious objection to
9 participating in specific health services, the statutes also recognize “the right of
10 individuals enrolled with plans . . . to receive the full range of services covered
11 under the plan.” Wash. Rev. Code 48.43.065(1); *see also* Wash. Rev. Code
12 70.47.160(1). The exercise of conscience rights cannot deprive an individual of
13 “coverage” or “timely access to” medical services. Wash. Rev. Code
14 48.43.065(3)(b); *see also* Wash. Rev. Code 70.47.160(3)(b).

15 41. As discussed further, below, Washington public policy and health
16 care statutes incorporate principles reflecting a recognition of conscience rights,
17 while also respecting the rights of Washington residents to receive appropriate
18 and fully informed medical care as required by federal law, state law, and
19 longstanding medical standards and ethical rules.

20

21

22

1 **2. The Reproductive Privacy Act, Wash. Rev. Code 9.02.100,**
2 ***et seq.***

3 42. Washington’s longstanding public policy supports women’s access
4 to a full range of reproductive health care services, including abortion. In 1970,
5 three years before *Roe v. Wade*, 410 U.S. 113 (1973), Washington voters passed
6 Referendum 20, becoming the first state to legalize elective abortion through the
7 popular vote. Referendum 20 permitted abortions within the first four months of
8 pregnancy when performed by, or under the supervision of, a licensed physician.
9 Laws of 1970, 2d Ex. Sess., ch. 3, § 2. By the mid-1970s, the state was providing
10 public funding for abortions for indigent women, which it continued to do after
11 federal funding was eliminated.

12 43. In 1991, Washingtonians again voted in favor of abortion rights,
13 adding detail and clarifying the proper role of the state. Laws of 1992, ch. 1,
14 §§ 1–13. Initiative 120, the Reproductive Privacy Act, declares that the “right of
15 privacy with respect to personal reproductive decisions” is a “fundamental right”
16 of each individual. Wash. Rev. Code 9.02.100. The Act prohibits the state from
17 discriminating against, denying, or interfering with a woman’s “right to choose
18 to have an abortion prior to viability of the fetus, or to protect her life or health.”
19 Wash. Rev. Code 9.02.100(4), .110. Any restriction on abortion is valid only if it
20 is medically necessary to protect the life or health of the woman, consistent with
21 established medical practice, and the least restrictive of all available alternatives.
22 Wash. Rev. Code 9.02.140.

1 44. Washington has always respected the conscience rights of providers
2 who object to providing abortion services. The 1970 ballot measure legalizing
3 elective abortion provided that “[n]o hospital, physician, nurse, hospital
4 employee nor any other person shall be under any duty . . . to participate in a
5 termination of pregnancy if such hospital or person objects to such termination.”
6 Laws of 1970, 2d Ex. Sess., ch. 3, § 3. The 1991 Reproductive Privacy Act
7 refined and replaced the language governing who may object, providing that
8 “[n]o person or private medical facility may be required by law or contract in any
9 circumstances to participate in the performance of an abortion if such person or
10 private medical facility objects to so doing.” Wash. Rev. Code 9.02.150.

11 **3. The Reproductive Parity Act, Wash. Rev. Code 48.43.072–.073**

12 45. In 2018, the Washington Legislature passed, and the Governor
13 signed, SSB 6219 (codified as Wash. Rev. Code 48.43.072 and .073), entitled the
14 Reproductive Parity Act. The Reproductive Parity Act requires that health plans
15 provide contraceptive coverage, and that a health plan providing coverage for
16 maternity care or services also include coverage for equivalent abortion services.

17 In the Act, the Washington Legislature declared that:

- 18 • Reproductive health care is the care necessary to support the
19 reproductive system, the capability to reproduce, and the
20 freedom and services necessary to decide if, when, and how
21 often to do so, which can include contraception, cancer and
22 disease screenings, abortion, preconception, maternity,
prenatal, and postpartum care. This care is an essential part of
primary care for women and teens, and often reproductive
health issues are the primary reason they seek routine medical
care;

- 1 • Neither a woman’s income level nor her type of insurance
2 should prevent her from having access to a full range of
3 reproductive health care, including contraception and
4 abortion services;
- 5 • Restrictions and barriers to health coverage for reproductive
6 health care have a disproportionate impact on low-income
7 women, women of color, immigrant women, and young
8 women, and these women are often already disadvantaged in
9 their access to the resources, information, and services
10 necessary to prevent an unintended pregnancy or to carry a
11 healthy pregnancy to term;
- 12 • This state has a history of supporting and expanding timely
13 access to comprehensive contraceptive access to prevent
14 unintended pregnancy;
- 15 • Nearly half of pregnancies in both the United States and
16 Washington are unintended. [. . .]
- 17 • Access to contraception has been directly connected to the
18 economic success of women and the ability of women to
19 participate in society equally.

20 Reproductive Parity Act, 2018 Wash. Sess. Laws, ch. 119 (SSB 6219).

21 46. Relevant here, the law has two parts. First, health plans issued or
22 renewed after January 1, 2019 must provide coverage for all contraceptives
approved by the federal Food and Drug Administration, voluntary sterilization
procedures, and any services necessary to provide the contraceptives. Wash. Rev.
Code 48.43.072(1). This coverage cannot be subject to cost sharing or a
deductible, unless the health plan is part of a health savings account. Wash. Rev.
Code 48.43.072(2)(a). Carriers cannot deny coverage because an enrollee
changed a contraceptive method changed within a twelve-month period, and the

1 health plan cannot impose any restrictions or delays on the enrollee’s ability to
2 receive this coverage. Wash. Rev. Code 48.43.072(3), (4). These benefits must
3 be offered to all enrollees, their enrolled spouses, and their enrolled dependents.
4 Wash. Rev. Code 48.43.072(5).

5 47. Second, health plans issued or renewed after January 1, 2019, that
6 provide coverage for maternity care or services must “also provide a covered
7 person with substantially equivalent coverage to permit the abortion of a
8 pregnancy.” Wash. Rev. Code 48.43.073(1).

9 48. During public testimony on SSB 6219, opponents argued that the
10 bill would “violate the constitutionally protected rights of religious organizations
11 and individuals.” Senate Bill Report, SSB 6219 at 5, *available at*
12 [http://lawfilesexternal.wa.gov/biennium/2017-18/Pdf/Bill%20Reports/Senate/
13 6219%20SBR%20WM%2018.pdf](http://lawfilesexternal.wa.gov/biennium/2017-18/Pdf/Bill%20Reports/Senate/6219%20SBR%20WM%2018.pdf) (last accessed May 23, 2019). Proponents
14 responded that the bill represented “a compromise . . . that protects religious
15 organizations but still protects women’s reproductive health.” *Id.* Those with
16 conscience or religious objections could still utilize the protections of Wash. Rev.
17 Code 48.43.065 to avoid purchasing services with which they hold a moral or
18 religious objection. Wash. House Health Care & Wellness Comm., Public Hrg.,
19 Feb. 7, 2018 at 33:12–39:30, *available at* [https://www.tvw.org/watch
20 /?eventID=2018021058](https://www.tvw.org/watch/?eventID=2018021058) (last accessed Apr. 17, 2019).

21
22

1 49. The Insurance Commissioner has proposed new rules implementing
2 SSB 6219. Office of the Insurance Commissioner, *Health Plan Coverage of*
3 *Reprod. Healthcare and Contraception Stakeholder Draft*, Sept. 20, 2018,
4 available at [https://www.insurance.wa.gov/sites/default/files/2018-09/2018-10-](https://www.insurance.wa.gov/sites/default/files/2018-09/2018-10-stakeholder-draft.pdf)
5 [stakeholder-draft.pdf](https://www.insurance.wa.gov/sites/default/files/2018-09/2018-10-stakeholder-draft.pdf) (last accessed April 17, 2019). The proposed rules make
6 clear that SSB 6219 does not preclude someone from exercising their rights under
7 Wash. Rev. Code 48.43.065: “This subchapter does not diminish or affect any
8 rights or responsibilities provided under [Wash. Rev. Code] 48.43.065.” *Id.* at 2.

9 **4. Informed consent, Wash. Rev. Code 7.70.050–.060**

10 50. Washington State also recognizes a patient’s right to determine the
11 course of their own medical treatment. Under Washington law, providers are
12 under a non-delegable fiduciary duty to obtain a patient’s informed consent
13 before engaging in a course of treatment. Wash. Rev. Code 7.70.050.

14 51. Unless a patient has been provided all the information necessary to
15 make a knowledgeable decision regarding their medical care, the patient’s
16 “consent” to the course of action taken by the health care provider is not
17 “informed.” The broad categories of information that must be disclosed to the
18 patient include: (1) the nature, character and anticipated results of the treatment,
19 (2) material risks inherent in the proposed treatment, and the (3) alternative
20 courses of treatment and their attendant risks. Wash. Rev. Code 7.70.060(1).

21
22

1 52. Consequently, if medical evidence establishes that there is an
2 alternative course of treatment, including nontreatment, the physician has a duty
3 to inform the patient of that alternative. *Archer v. Galbraith*, 18 Wash. App. 369,
4 379, 567 P.2d 1155 (1977).

5 53. Washington hospitals also play a role in the informed consent
6 process. They must ensure the patient’s right to be involved in all aspects of their
7 care including obtaining informed consent. Wash. Admin Code 246-330-125
8 (requiring that ambulatory surgical facilities provide their patients with a copy of
9 their rights which include, among other things, the right to “[b]e informed and
10 agree to their care.”); Wash. Admin. Code 246-320-166(4)(c) (requiring hospitals
11 to include “consent documents” as part of a patient’s medical records).

12 54. Washington’s informed consent statute is consistent with
13 longstanding medical standard of care principles and medical ethics. By way of
14 example, in the context of reproductive care, medical providers are ethically
15 required to provide a patient with “pertinent medical facts and recommendations
16 consistent with good medical practice.” ACOG, Code of Professional Ethics,
17 *available at* [https://www.acog.org/About-ACOG/ACOG-Departments/
18 Committees-and-Councils/Volunteer-Agreement/Code-of-Professional-Ethics-
19 of-the-American-College-of-Obstetricians-and-Gynecologists](https://www.acog.org/About-ACOG/ACOG-Departments/Committees-and-Councils/Volunteer-Agreement/Code-of-Professional-Ethics-of-the-American-College-of-Obstetricians-and-Gynecologists) (last accessed
20 May 23, 2019); *see also* American Medical Association, AMA Code of Medical
21 Ethics (2016) *available at* <https://www.ama-assn.org/sites/ama-assn.org/>
22

1 | [files/corp/media-browser/code-of-medical-ethics-chapter-2.pdf](#) (last accessed
2 | May 23, 2019) (a provider that withholds medical information is in violation of
3 | the medical code of ethics).

4 | 55. To that end, medical providers counseling pregnant patients must
5 | provide “complete, medically accurate and unbiased information and resources
6 | for all of their pregnancy options,” including prenatal care, abortion, and other
7 | options for which the patient may want information. ACOG Executive Board,
8 | Abortion Policy 2014 Statement Of Policy 1, *available at* <https://www.acog.org/-/media/Statements-of-Policy/Public/sop069.pdf> (last accessed May 23, 2019);
9 | *see also* ACOG, Comm. on Ethics, *Opinion No. 528, Adoption*, 119 *Obstetrics &*
10 | *Gynecology* 1320, 1320 (2012), *available at* [https://www.acog.org/Clinical-](https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/Adoption)
11 | [Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/](https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/Adoption)
12 | [Adoption](https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/Adoption) (last accessed May 23, 2019) (reaffirmed in 2018). In order to be fully
13 | informed, the discussion between the health care provider and the patient must
14 | also take place in an environment free from personal bias, coercion, or undue
15 | influence.
16 |

17 | 56. Washington’s informed consent statute does not conflict with
18 | conscience principles. A medical provider does not have to participate in
19 | procedures to which they object on moral or religious grounds, but, as a matter
20 | of law, they have not obtained the requisite informed consent if they withhold
21 | information related to those medical procedures from their patient.
22 |

1 **5. Regulation of pharmacies’ responsibilities, Wash. Admin Code**
2 **246-869-010**

3 57. The practice of pharmacy in the state of Washington is regulated by
4 the Washington Pharmacy Quality Assurance Commission pursuant to a
5 comprehensive regulatory scheme that directs the Commission, among other
6 responsibilities, to “[r]egulate the practice of pharmacy and enforce all laws
7 placed under its jurisdiction” and “[p]romulgate rules for the dispensing,
8 distribution, wholesaling, and manufacturing of drugs and devices and the
9 practice of pharmacy for the protection and promotion of the public health, safety,
10 and welfare.” Wash. Rev. Code 18.64.005. The “practice of pharmacy” “includes
11 the practice of and responsibility for: [i]nterpreting prescription orders [and] the
12 compounding, dispensing, labeling, administering, and distributing of drugs and
13 devices,” in addition to information-sharing and monitoring responsibilities.
14 Wash. Rev. Code 18.64.011(11).

15 58. In January 2006, the predecessor to the Commission, the
16 Washington Board of Pharmacy, became concerned with the lack of clear
17 authority regarding destruction or confiscation of lawful prescriptions and
18 refusals by pharmacists to dispense lawfully prescribed medications.
19 Recognizing the importance of providing Washington patients timely access to
20 all medications, the Board initiated a rulemaking process to address these issues.
21 *See Stormans, Inc. v. Selecky*, 586 F.3d 1109, 1114 (9th Cir. 2009).

1 59. After considering a number of draft rules, the Board adopted two
2 rules by unanimous vote on April 12, 2007. The first rule, an amendment to
3 Wash. Admin. Code 246-863-095, governs pharmacists. Under this rule, a
4 pharmacist may be subject to professional discipline for destroying or refusing to
5 return an unfilled lawful prescription, violating a patient's privacy, or unlawfully
6 discriminating against, or intimidating or harassing a patient. The rule, however,
7 does not require an individual pharmacist to dispense medication in the face of a
8 personal objection.

9 60. The second rule, Wash. Admin. Code 246-869-010, governs
10 pharmacies. It requires pharmacies “to deliver lawfully prescribed drugs or
11 devices to patients and to distribute drugs and devices approved by the U.S. Food
12 and Drug Administration for restricted distribution by pharmacies . . . in a timely
13 manner consistent with reasonable expectations for filling the prescription.”
14 Wash. Admin Code 246-869-010(1). A pharmacy may substitute a
15 “therapeutically equivalent drug” or provide a “timely alternative for appropriate
16 therapy,” but apart from certain necessary exceptions, a pharmacy is prohibited
17 from refusing to deliver a lawfully prescribed or approved medicine. Wash.
18 Admin. Code 246-869-010(1), (3), (4). A pharmacy is also prohibited from
19 destroying or refusing to return an unfilled lawful prescription, violating a
20 patient’s privacy, unlawfully discriminating against, or intimidating or harassing
21 a patient. Wash. Admin Code 246-869-010(4).
22

1 61. In the Concise Explanatory Statement accompanying the
2 regulations, the Board noted that it created a right of refusal for individual
3 pharmacists by allowing a pharmacy to accommodate a pharmacist who has a
4 religious or moral objection. A pharmacy may not refer a patient to another
5 pharmacy to avoid filling a prescription because the pharmacy has a duty to
6 deliver lawfully prescribed medications in a timely manner. A pharmacy may
7 accommodate a pharmacist's personal objections in any way the pharmacy deems
8 suitable, including having another pharmacist available in person or by
9 telephone.

10 **6. Washington Charity Care Law, Wash. Rev. Code 70.170.060**

11 62. Washington has enacted charity care legislation that requires
12 hospitals to provide free or discounted inpatient and outpatient care to low
13 income patients. Washington's law requires that hospitals and their staff provide
14 emergency care to patients regardless of their ability to pay. Wash. Rev. Code
15 70.170.060. Similar to the federal EMTALA, a patient in an emergency medical
16 condition or active labor cannot be transferred unless by patient request or
17 because the hospital has limited medical resources. Wash. Rev. Code
18 70.170.060(2). A transfer must follow reasonable procedures, which include but
19 are not limited to confirming that the receiving hospital accepts the transfer. *Id.*

1 **7. Emergency contraception for sexual assault victims, Wash.**
2 **Rev. Code 70.41.350**

3 63. Emergency contraception prevents pregnancy, and is commonly
4 used after a sexual assault. Washington law (Wash. Rev. Code 70.41.350) and
5 the rules to enact it (Wash. Admin. Code 246-320-286) require all hospitals with
6 emergency rooms to provide emergency contraception as a treatment option to
7 any woman who seeks treatment as a result of a sexual assault.

8 64. Hospitals providing emergency care to a victim of sexual assault
9 must: (1) develop and implement policies and procedures regarding the provision
10 of twenty-four-hour/seven-days per week emergency care to victims of sexual
11 assault; (2) provide the victim of sexual assault with medically and factually
12 accurate and unbiased written and oral information about emergency
13 contraception; (3) orally inform each victim in a language she understands of her
14 option to be provided emergency contraception at the hospital; and (4)
15 immediately provide emergency contraception if the victim requests it, and if the
16 emergency contraception is not medically contraindicated. Wash. Admin. Code
17 246.320.286.

18 **8. Duty to comply with advanced directives, Wash. Rev. Code**
19 **70.122.030**

20 65. Washington residents may execute a directive that requires health
21 care providers to withhold or withdraw life-sustaining treatment if they are a
22 terminal or semi-conscious condition. Wash. Rev. Code 70.122.030. These
directives become a part of the patient's medical records and are forwarded to the

1 patient's health care facility. Under Washington law, no nurse, physician or other
2 health care provider can be required to participate in the withholding or
3 withdrawal of life sustaining treatment if they have an objection. Wash. Rev.
4 Code 70.122.060(2). When an attending physician or health care facility becomes
5 aware of a patient's advance directive, however, they *must* inform the patient of
6 any policy or practice that would preclude them from honoring the patient's
7 directive. Wash. Rev. Code 70.122.060(2).

8 **9. Information concerning end-of-life care options, Wash. Rev.**
9 **Code 70.245**

10 66. Washington State recognizes that residents suffering a terminal
11 disease may make an informed decision to self-administer medication to end their
12 own life in a humane and dignified manner. The Washington Death with Dignity
13 Act, Initiative 1000 (DWDA), passed by popular vote on November 4, 2008 and
14 went into effect on March 5, 2009. Wash. Rev. Code 70.245. Under the DWDA,
15 terminally ill adults seeking to end their life may request lethal doses of
16 medication from medical and osteopathic physicians.

17 67. The DWDA requires a patient to make two oral requests for life
18 ending medications, and that they submit a written request with specific
19 information which must be signed by two qualified witnesses. Wash. Rev. Code
20 70.245.030. Two physicians, a prescribing physician and a consulting physician,
21 must confirm the patient's terminal diagnosis, the patient's intent to end their life,
22 and the patient's capacity to make an informed decision. Wash. Rev. Code

1 70.245.070; *see also* Wash. Rev. Code 70.245.120. A patient must then wait
2 forty-eight hours before receiving life-ending medication, and must
3 self-administer the medication.

4 68. The DWDA acknowledges the conscience rights of providers,
5 explicitly stating that providers are not required to “participate” in a patient’s
6 request under the DWDA. Wash. Rev. Code 70.245.190. In addition, it allows
7 health care facilities to take adverse action against attending physicians,
8 consulting physicians and any individuals who perform a counseling function if
9 they participate in the DWDA despite knowing that the health care provider has
10 policies against providing DWDA services. Wash. Rev. Code 70.245.190(2)(b).
11 Among other things, a non-participating health care facility can terminate
12 privileges and employment. *Id.*

13 69. The DWDA defines “participation” narrowly, however, and does
14 not permit sanctions if the counselor, attending physician or consulting physician
15 is simply providing information about the Washington DWDA, or providing a
16 referral to another physician upon a patient’s request. Wash. Rev. Code
17 70.245.190(d). If a health care provider is unwilling to carry out the request, and
18 the patient transfers his or her care to a new health care provider, the non-
19 participating provider must transfer, upon request, a copy of the patient’s relevant
20 medical records. *Id.*

21
22

1 **10. Services for LGBTQ individuals**

2 70. In 2019, the Washington Legislature passed, and the Governor
3 signed, 2SSB 5602, entitled “An Act relating to eliminating barriers to
4 reproductive health care for all.” The Act resulted from a report submitted to the
5 Legislature on January 1, 2019. The report was generated in response to a
6 legislatively mandated review of barriers to reproductive health care. In response
7 to this report, the Legislature found that “Washingtonians who are transgender
8 and gender nonconforming have important reproductive health care
9 needs . . . [which] go unmet when, in the process of seeking care, transgender and
10 gender nonconforming people are stigmatized or are denied critical health
11 services because of their gender identity or expression.” 2019 Wash. Sess. Laws,
12 ch. 399, § 1(3). Thus, the Legislature found that “all Washingtonians, regardless
13 of gender identity, should be free from discrimination in the provision of health
14 care services, health care plan coverage, and in access to publicly funded health
15 coverage.” *Id.* § 1(6).

16 71. Relevant here, the Act prohibits programs regulated by the
17 Washington State Health Care Authority from discriminating based on gender
18 identity or expression. The Washington State Health Care Authority is the largest
19 health care purchaser in Washington and purchases health care for Washington
20 residents through Apple Health (Medicaid), the Public Employees Benefits
21 Board Program, and beginning in 2020, the School Employees Benefit Board
22

1 Program. Specifically, the Act amends chapter 74.09 Wash. Rev. Code to provide
2 that: “In the provision of reproductive health care services through programs
3 under this chapter, the [Health Care Authority], managed care plans, and
4 providers that administer or deliver such services may not discriminate in the
5 delivery of a service provided through a program of the authority based on the
6 covered person’s gender identity or expression.” 2019 Wash. Sess. Laws, ch. 399,
7 § 2(1).

8 72. The Act further clarifies that it shall be prohibited discrimination
9 under chapter 49.60 Wash. Rev. Code for the Health Care Authority or any
10 managed care plan delivering services purchased or contracted for by the
11 authority to make any “automatic initial denials of coverage for reproductive
12 health care services that are ordinarily or exclusively available to individuals of
13 one gender, based on the fact that the individual’s gender assigned at birth, gender
14 identity, or gender otherwise recorded in one or more government-issued
15 documents, is different from the one to which such health services are ordinarily
16 or exclusively available.” *Id.* § 2(2) and (3). The Act takes effect on July 28,
17 2019.

18 **11. Patient abandonment**

19 73. In 1942, the Washington Supreme Court established the rule on the
20 appropriate manner of a provider to withdraw patient care: “It is the general rule
21 that when a physician undertakes to treat a patient, it is his duty to continue to
22

1 devote his best attention to the case until either medical attention is no longer
2 needed, he is discharged by the patient, or he has given the patient reasonable
3 notice of his intention to cease to treat the patient, so that another physician may
4 be obtained.” *Gray v. Davidson*, 15 Wash. 2d 257, 266–267, 130 P.2d 341 (1942).
5 Washington has incorporated these principles in a number of statutes and
6 regulations addressing the practice of medicine and the provision of medical
7 services. *E.g.*, Wash. Admin. Code 246-840-710 (abandoning a patient without
8 an appropriate transfer constitutes a violation of the standards of nursing conduct
9 and practice).

10 74. The Washington State Medical Association acknowledges that
11 physicians may choose whom to serve pursuant to their conscience objection.
12 However, “other principles balance this prerogative with obligations to respect
13 patients and their ability to access available medical care. Therefore, a
14 conscientious objection should, under most circumstances, be accompanied by a
15 referral to another physician or health care facility.” WSMA Policy
16 Compendium, *available at* [https://wsma.org/WSMA/About/Policies/Policies](https://wsma.org/WSMA/About/Policies/Policies.aspx)
17 [.aspx](https://wsma.org/WSMA/About/Policies/Policies.aspx) (last accessed May 23, 2019).
18
19
20
21
22

1 **C. HHS's 2019 Final Rule**

2 **1. Background**

3 75. On May 2, 2019, President Trump announced the finalization of the
4 rule in a Rose Garden speech during the National Day of Prayer Service.⁵ Directly
5 after that announcement, President Trump said, "Together we are building a
6 culture that cherishes the dignity and worth of human life. Every child, born and
7 unborn is a sacred gift from God." That day, HHS published the text of the Final
8 Rule on its website.

9 76. On May 21, 2019, HHS issued the Final Rule⁶ to expand and
10 consolidate its Office of Civil Rights' (OCR) enforcement authority over nearly

11 _____
12 ⁵ Remarks by President Trump at the National Day of Prayer Service,
13 May 2, 2019, available at [https://www.whitehouse.gov/briefings-statements](https://www.whitehouse.gov/briefings-statements/remarks-president-trump-national-day-prayer-service/)
14 [/remarks-president-trump-national-day-prayer-service/](https://www.whitehouse.gov/briefings-statements/remarks-president-trump-national-day-prayer-service/) (last accessed May 23,
15 2019).

16 ⁶ *Protecting Statutory Conscience Rights in Health Care; Delegations of*
17 *Authority*, 84 Fed. Reg. 23170 (May 21, 2019), available at
18 [https://www.govinfo.gov/content/pkg/FR-2019-05-21/pdf/2019-09667.pdf?utm](https://www.govinfo.gov/content/pkg/FR-2019-05-21/pdf/2019-09667.pdf?utm_campaign=subscription%20mailing%20list&utm_source=federalregister.gov&utm_medium=email)
19 [_campaign=subscription%20mailing%20list&utm_source=federalregister.gov&](https://www.govinfo.gov/content/pkg/FR-2019-05-21/pdf/2019-09667.pdf?utm_campaign=subscription%20mailing%20list&utm_source=federalregister.gov&utm_medium=email)
20 [utm_medium=email](https://www.govinfo.gov/content/pkg/FR-2019-05-21/pdf/2019-09667.pdf?utm_campaign=subscription%20mailing%20list&utm_source=federalregister.gov&utm_medium=email) (last accessed May 22, 2019). The PDF version of the Final
21 Rule on the Federal Register website, linked at note 1, erroneously dates it one
22 year prior, May 21, 2018. The version posted on the Federal Register website

1 thirty federal health care conscience laws, including three parts of the ACA.
2 These laws focus largely on abortion but some also address sterilization
3 procedures, health care counseling, physician-assisted suicide, and advance
4 directives, among other types of medical care.

5 77. The Final Rule dramatically expands the reach of the federal statutes
6 it purports to interpret. It makes the refusal rights of individuals and institutions
7 absolute and categorical. It broadly allows providers to refuse to engage in health
8 care counseling, so that patients may not even know they are being denied
9 knowledge of their full range of options. It applies not just to health care
10 professionals but to any employee, so a clinic receptionist or a health insurer's
11 customer representative may refuse to perform their normal work
12 responsibilities. It also applies to non-health care providers such as insurance
13 companies and non-health employers. And States are required to police their
14 subrecipients' compliance with the Final Rule if they receive any federal funds,
15 so that an unknown violation of the rule by a recipient of a pass-through of HHS
16 financial assistance could result in the termination of the State's entire multi-
17 billion dollar federal Medicaid match.

18
19 _____
20 bears the correct date of May 21, 2019. See [https://www.federalregister.gov/
21 documents/2019/05/21/2019-09667/protecting-statutory-conscience-rights-in-
22 health-care-delegations-of-authority](https://www.federalregister.gov/documents/2019/05/21/2019-09667/protecting-statutory-conscience-rights-in-health-care-delegations-of-authority) (last accessed May 23, 2019).

1 78. The substantive provisions of the Final Rule attempt to track the
2 statutory language of the nearly thirty laws. However, the Rule defines many key
3 terms—such as “discrimination,” “health care entity,” and “referral”—in ways
4 that significantly broaden the prior application of these laws. The Final Rule now
5 applies to entities that include state governments, federally recognized tribes,
6 hospitals, skilled nursing facilities, home health care providers, doctor’s offices,
7 front desk staff, insurance companies, ambulance providers, pharmacists,
8 pharmacies, and many non-health employers that offer insurance to their
9 employees.

10 **2. Definitions section**

11 79. The definitions section of the Final Rule includes a number of
12 changes to prior definitions, as well as newly defined terms.

13 **a. “Assist in the performance”**

14 80. The Church Amendments prohibit individuals from being forced to
15 perform or “assist in the performance” of procedures or health care services
16 involving abortion or sterilization that are contrary to their religious beliefs or
17 moral convictions. The Final Rule defines “assist in the performance” as taking
18 an action that has a specific, reasonable, and articulable connection to furthering
19 a procedure or part of a health service program or research activity undertaken
20 by or with another person or entity. This may include counseling, referral,
21
22

1 training, or otherwise making arrangements for the procedure, program, or
2 research activity.

3 81. This definition extends to non-medical staff (such as front desk
4 staff) and other segments of the health care workforce (such as ambulance
5 drivers). HHS states that a person preparing a room for an abortion or scheduling
6 an abortion could fall under the definition—as could driving a person to a hospital
7 or clinic with a ruptured ectopic pregnancy, where termination of the pregnancy
8 is a reasonable likelihood. Emergency medical technicians and paramedics may
9 claim protection under the rule.

10 82. Two sections of this definitional section are dramatic in their
11 breadth. One purports to make options counseling completely discretionary for
12 providers and institutions with conscience-based objections, even if the options
13 are medically indicated for the patient’s condition. HHS defines “assist in the
14 performance” to encompass medical counseling, including informing patients of
15 their available options under the applicable standard of care. Final Rule § 88.2.
16 Thus, the Final Rule makes advising patients of their options in light of their
17 medical condition optional for those who refuse on conscience grounds to “assist
18 in” particular treatment.

19 83. Another section purports to allow providers and institutions to
20 interpose religious or moral refusals to services beyond abortion and sterilization,
21 the stated subjects of the Church Amendments, authorizing them to deny services
22

1 to members of the LGBTQ community. *See* 42 U.S.C. § 300a-7 (entitled
2 “Sterilization or abortion”). The Final Rule prohibits discrimination against a
3 person assisting “in any lawful health service” who asserts a conscience-based
4 objection, Final Rule § 88.3(a)(2)(v), and prohibits covered entities from
5 requiring any objecting person to assist in the performance of “any part of a health
6 service program.” *Id.* § 88.3(a)(2)(vi).

7 **b. “Discriminate” or “discrimination”**

8 84. The Final Rule includes a definition for “discriminate” or
9 “discrimination,” which was previously undefined. HHS defines these terms to
10 include (1) withholding, reducing, excluding, terminating, restricting, or
11 otherwise making unavailable or denying any grant, contract, subcontract,
12 cooperative agreement, loan, license, certification, accreditation, employment,
13 title, or other similar instrument, position, status, benefit, or privilege or imposing
14 any penalty; and (2) using any criterion, method of administration, or site
15 selection (including the enactment, application, or enforcement of laws,
16 regulations, policies, or procedures directly or through contractual or other
17 arrangements) that subjects protected individuals or entities to any adverse
18 treatment.

19 85. The Final Rule partially incorporates Title VII’s approach to the
20 reasonable accommodation of religion—but without the “undue hardship”
21 exception. Entities will not have engaged in discrimination if they offer an
22

1 effective accommodation for the exercise of protected conduct, religious beliefs,
2 or moral convictions (assuming that offer is voluntarily accepted). Employers can
3 inform the public of the availability of alternate staff or methods but are not
4 required to do so and cannot single out staff if doing so would be retaliatory.

5 86. Objecting employees can be required to disclose their objections to
6 the employer if there is a reasonable likelihood that they would be asked to take
7 this action.

8 **c. “Entity” and “health care entity”**

9 87. The Final Rule includes separate definitions for “entity” and “health
10 care entity” and, in doing so, expands the application of federal conscience laws
11 that refer to “entity.” Under the predecessor rule, the definition for “entity” and
12 “health care entity” had been identical, limiting application of federal conscience
13 laws to health care entities (such as health care professionals).

14 88. The definition of “entity” has been broadened to include “persons”
15 (individuals, corporations, companies, associations, firms, partnerships,
16 societies, and joint stock companies), states, political subdivisions, state
17 instrumentalities or political divisions, and any public agency, public institution,
18 public organization, or other public entity.

19 89. Three of the statutes—the Weldon Amendment, the Coats-Snowe
20 Amendment, and Section 1553 of the ACA—use the term “health care entity.”
21 For all three statutes, “health care entity” includes an individual physician or
22

1 other health care professional (including a pharmacist); health care personnel; a
2 participant in a health professions training program; an applicant for training or
3 study in the health professions; a post-graduate physician training program; a
4 hospital; a medical laboratory; an entity engaging in biomedical or behavioral
5 research; a pharmacy; any other health care provider or facility; and (potentially)
6 a component of state or local government. HHS added pharmacies and
7 pharmacists in the Final Rule.

8 90. For purposes of the Weldon Amendment and Section 1553, a
9 “health care entity” additionally includes provider sponsored-organizations,
10 HMOs, issuers, group and individual health insurance plans, plan sponsors, and
11 third-party administrators. The inclusion of plan sponsors in the definition applies
12 to all employers that sponsor a group health plan even when they are not
13 otherwise a “health care entity.”

14 **d. “Health service program”**

15 91. The Final Rule eliminated the definition of “health program or
16 activity” and refers only to “health service program.” A health service program
17 includes any health or health-related services or research activities, benefits,
18 insurance coverage, studies, or any other service related to health or wellness.
19 The definition includes programs provided or administered directly, through
20 insurance, or through payments, grants, contracts, or other instruments.

21
22

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

e. “Referral” or “refer for”

92. The Final Rule defines “referral” or “refer for” to include providing information in oral, written, or electronic form (including names, addresses, phone numbers, email or web addresses, directions, instructions, descriptions, or other information resources) where the purpose or reasonably foreseeable outcome of providing that information is to assist a person in receiving funding or financing for, training in, obtaining, or performing a particular health care service, program, activity, or procedure.

93. Under this definition, an individual would not have to provide contact information of a physician or clinic that may provide an abortion, tell a patients that funding is available for abortion, or provide a phone number where they can be referred to abortion services or funding.

3. Assurance and certification

94. Under the Final Rule, every application for federal funding from HHS must include both an assurance and a certification that the applicant or recipient will comply with applicable federal conscience laws. Final Rule § 88.4(a).

4. Compliance and enforcement

95. HHS states that each recipient of HHS funds “has primary responsibility to ensure that it is in compliance with” the Final Rule. Final Rule § 88.6(a). Further, if HHS finds that a subrecipient of federal funds, such as a

1 clinic included in a state’s federally subsidized Title X network, violated the Final
2 Rule, the state “may be subject to the imposition of funding restrictions or any
3 appropriate remedies available under this part” *Id.*

4 96. OCR has discretion in choosing its means of enforcement, which
5 could range from informal resolution to more rigorous enforcement. In response
6 to a violation, OCR could terminate federal funds, withhold federal payments,
7 withhold new federal funds, suspend award activities, refer a matter to the
8 Department of Justice, or take other remedies.

9 **5. Preemption**

10 97. The Final Rule contains a provision that addresses preemption of
11 state laws. Final Rule § 88.8. This provision states that it does *not* preempt only
12 those state laws that are *equally or more protective of* religious freedom and
13 moral convictions. In contrast, HHS purports to preempt state laws, such as those
14 in Washington, that balance conscience objections with guarantees of patient
15 access to care. “To the extent State or local standards or laws conflict with the
16 Federal laws that are the subject of this rule, the Federal conscience and
17 antidiscrimination laws preempt such laws and standards” 48 Fed. Reg. at
18 23266.

1 **D. The Final Rule’s Impact on Washington**

2 **1. Abrogation of Washington’s laws protecting patients**

3 98. Washington has a sovereign interest in its “power to create and
4 enforce a legal code.” *Alfred L. Snapp & Son, Inc. v. Puerto Rico ex rel. Barez*,
5 458 U.S. 592, 601 (1982); *see also Bowen v. Pub. Agencies Opposed to Soc. Sec.*
6 *Entrapment*, 477 U.S. 41, 51 n.17 (1986) (there is “no question” that states have
7 standing to sue to preserve their sovereignty where sovereign interests have been
8 interfered with or diminished).

9 99. As reflected in numerous laws in Washington’s legal code, the
10 Washington legislature has carefully balanced the right of individuals and
11 organization to refuse to provide health care services because of conscience
12 objections with Washingtonians’ rights “to receive the full range of services”
13 covered under the state’s health insurance plans.” Wash. Rev. Code 48.43.065.
14 These laws include the Reproductive Privacy Act, Wash. Rev. Code 9.02.100, *et*
15 *seq.*; the Reproductive Parity Act, Wash. Rev. Code 48.43.072–.073;
16 Washington’s Informed Consent statute, Wash. Rev. Code 7.7.050;
17 Washington’s regulation governing pharmacies’ responsibilities, Wash. Admin.
18 Code 246-869-010; its statute mandating emergency contraception for sexual
19 assault victims, Wash. Rev. Code 70.41.350; the duty to counsel on advanced
20 directives, Wash. Rev. Code 70.122.060(2); the duty to transfer medical records
21 of patients seeking end-of-life care, Wash. Rev. Code 70.245.190(d); the statute
22

1 prohibiting health care-related discrimination based on gender identity, 2019
2 Wash. Sess. Laws, ch. 399, § 2(1); and Washington’s charity care law prohibiting
3 patient abandonment, among other laws. *See supra* at Section B.1.

4 100. The Final Rule purports to preempt these Washington laws,
5 impeding Washington from enforcing its legal code. Under the Final Rule, HHS
6 could argue that Washington is barred from taking action against a hospital that
7 refused to provide emergency contraception to a victim of sexual assault. HHS
8 could assert that the State is powerless to enforce its regulations ensuring that
9 pharmacies fill a person’s lawful prescription for contraception. It could impede
10 the Attorney General from acting under state civil rights laws against health care
11 providers who refused to provide medically indicated services to gay or
12 transgender patients because they had a moral objection to them. Further, it could
13 threaten Washington with the loss of over \$10 billion in HHS funding if the State
14 did not acquiesce, forcing it to choose between its civil rights laws and its
15 Medicaid and children’s health insurance programs.

16 2. Denied or delayed health care to Washingtonians

17 101. Washington has a quasi-sovereign interest in “ensuring that the State
18 and its residents are not excluded from the benefits that are to flow from
19 participation in the federal system.” *Alfred L. Snapp & Son, Inc.*, 458 U.S. at 608.
20 “[F]ederal statutes creating benefits . . . create interests that a State will obviously
21 wish to have accrue to its residents.” *Id.* Washington’s quasi-sovereign interests
22

1 include “the health and well-being—both physical and economic—of its
2 residents in general,” and “assuring the benefits of the federal system are not
3 denied to its general population.” *Id.* at 607–08.

4 102. The Final Rule will jeopardize the health of Washington residents
5 and cause injury to patients seeking medically indicated reproductive care,
6 sterilization, options counseling, emergency contraception, and other forms of
7 health care. Washingtonians will be denied their guaranteed rights to prompt
8 health care consistent with applicable medical and ethical standards because of
9 conscience-based refusals. These refusals could come not only from medical
10 professionals but from orderlies, cabulance drivers, appointment schedulers, or
11 insurance company telephone representatives.

12 103. To illustrate the potential serious harm to Washington residents,
13 consider a hypothetical patient in Skagit County with a high-risk pregnancy who
14 regularly sees an OB/GYN high-risk specialist at the University of Washington.
15 Her OB/GYN determines that she is miscarrying and, under applicable standards
16 of care, she needs to be treated immediately to prevent infection, sepsis, and even
17 death. Washington law would prevent a hospital faced with a patient in an
18 emergency condition from refusing care and transferring the patient to a different
19 institution. Under the Final Rule, however, the nearest hospital could refuse to
20 admit her if it opposed pregnancy terminations on religious grounds, and it could
21 force the woman to be transported to Seattle for care.

22

1 104. As another illustration, consider an elderly resident of Benton
2 County terminally ill with aggressive, stage four liver cancer, who seeks to avoid
3 a painful end to his long life. He consults with a physician at the only healthcare
4 system near his rural home and makes a request for life-ending medications
5 consistent with the DWDA. Under the DWDA, a non-participating provider must
6 inform the patient that it does not provide services under the DWDA, and it must
7 transfer his records to a new health care provider. Under the Final Rule, however,
8 the institution does not need to inform the patient that it declines to participate in
9 the DWDA, and it could delay or refuse his request to transfer his records to a
10 participating provider. The patient could experience an avoidable, painful death
11 without ever learning that the facility does not participate in the DWDA.

12 105. Or, alternatively, consider a college student who is a victim of a
13 violent sexual assault. She is transported to a hospital emergency room, and she
14 requests the morning after pill. Washington law requires the hospital to
15 immediately provide her emergency contraception. Under the Final Rule,
16 however, the hospital may refuse to provide the medication because of a religious
17 policy objecting to terminating pregnancies, and instead—against her wishes—it
18 may counsel her on adoption or social services available to pregnant teens.

19 **3. Impact on state health care institutions**

20 106. “As a proprietor, [a state] is likely to have the same interests as other
21 similarly situated proprietors . . . , [a]nd like other such proprietors it may at times
22

1 need to pursue those interests in court.” *Snapp*, 458 U.S. at 601–02. Washington
2 operates numerous health care entities covered by the Final Rule. Consistent with
3 state law and standards of medical ethics, Washington health care entities
4 prioritize patient care and prohibit discrimination of care. By imposing an
5 absolute duty on health care providers to accommodate the religious objections
6 of any employee to providing any service to any patient—no matter the burden it
7 imposes on the provider, other employees, or the patient—the Final Rule invites
8 and sanctions discrimination against patients based on protected characteristics
9 such as sexual orientation or gender identity.

10 **4. Financial injury to Washington**

11 107. “It is a bedrock proposition that ‘a relatively small economic loss—
12 even an identifiable trifle—is enough to confer standing.’” *Massachusetts v. U.S.*
13 *Dep’t of Health & Human Servs.*, No. 18-1514, 2019 WL 1950427, at *9 (1st
14 Cir. May 2, 2019) (quoting *Katz v. Pershing, LLC*, 672 F.3d 64, 76 (1st Cir.
15 2012)). Washington faces far more than a small economic loss from the
16 enforcement and penalty provisions of the Final Rule, which place at risk,
17 alternatively, all “Federal financial assistance or other federal funds, in whole or
18 in part,” Final Rule § 88.7(i)(3)(i), or “Federal financial assistance or other
19 federal funds from the Department [of Health and Human Services], in whole or
20 in part,” Final Rule § 88.7(i)(3)(ii), (iv), and (v).

21
22

1 108. Based on information maintained by the Washington Office of
2 Financial Management, in 2018 Washington received over \$10.5 billion annually
3 in financial assistance of other federal funds from HHS. The enforcement
4 provisions of the Final Rule allow HHS to withhold, deny, suspend, or terminate
5 billions of dollars in federal health care funds to Washington in HHS's discretion.
6 According to publicly available information on HHS's Tracking Accountability
7 in Government Grants System (TAGGS), Washington received over \$8.9 billion
8 in federal funding from HHS in the 2018 federal fiscal year for entities identified
9 as being at the state level in the TAGGS system. The Final Rule threatens this
10 funding should HHS determine, in its discretion, that Washington or any of its
11 subrecipients is not complying with the Final Rule or any of the statutes it
12 implements. Specifically, in fiscal year 2018, this money included:

13 a. \$8.2 billion in funding for Washington's Medicaid and
14 Children's Health Insurance Program.

15 b. Over \$64 million in funding to the Washington Department
16 of Health for a variety of programs and assistance including Title X,
17 Medicare Entitlement for Washington Health, TB Elimination and
18 Laboratory Cooperative Agreements, Universal Newborn Hearing
19 Screening, Maternal and Child Health Services, Washington State
20 Department of Health Integrated HIV Surveillance and Prevention
21 Programs, Hospital Preparedness Programs, and many others.
22

1 c. Over \$108 million in funding to the Washington Health Care
2 Authority for a variety of programs including Block Grants for Mental
3 Health Services, Substance Abuse Prevention and Treatment Block
4 Grants, Opioid Response Grants, and many others.

5 d. Several million dollars in funding to the Washington
6 Department of Social and Health Services for a variety of programs
7 including Refugee Cash and Medical Assistance, Refugee Social Services,
8 employment services to individuals suffering severe mental illness and co-
9 occurring substance disorders through the Becoming Employed Starts
10 Today program, and many others.

11 109. In addition to the denial of federal funds, the Final Rule will impose
12 other direct costs on Washington. The Final Rule gives HHS authority to
13 financially penalize Washington if a subrecipient of federal funds violates the
14 Final Rule. Final Rule § 88.6(a). As a result, Washington will be required to
15 expend added funds, staffing, and other resources to review and monitor
16 subrecipients' policies, compliance, and complaints regarding refusal rights. For
17 example, the Washington Department of Health (DOH) administers and co-funds
18 with HHS a family planning program comprised of eighty-five clinics providing
19 free or low-cost contraceptives and other reproductive health services to
20 low-income people in thirty-two of Washington's thirty-nine counties. This
21 network of clinics is operated by subrecipients that DOH compensates in part
22

1 with funds from HHS’s Title X grant to the State. The Final Rule will require
2 DOH’s Family Planning Program to expend additional staff, resources, and funds
3 on monitoring and ensuring compliance with the absolute refusal rights the Final
4 Rule purports to create for its Title X family planning provider subgrantees.

5 **V. CLAIMS FOR RELIEF**

6 **Count I**

7 **Violation of the Administrative Procedure Act**
8 **Agency Action Not in Accordance with Law—Claimed HHS Authority**

9 110. Washington realleges and reincorporates by reference the
10 allegations set forth in each of the preceding paragraphs.

11 111. The APA requires that agency action that is “not in accordance with
12 law” be held unlawful and set aside. 5 U.S.C. § 706(2).

13 112. The Final Rule violates the statutes HHS purports to interpret by
14 adopting constructions of them not intended or authorized by Congress. HHS’s
15 unlawfully broad interpretations of these statutes include making the refusal
16 rights of individuals and institutions absolute and categorical; broadly allowing
17 providers to refuse to engage in health care counseling; applying its provisions
18 not just to health care professionals but to any employee; applying its provisions
19 to non-health care providers such as insurance companies and non-health
20 employers; and imposing on Washington the responsibility to police the
21 compliance with the rule of its subrecipients of federal funds.

22 113. In addition, the Final Rule purports to create a mechanism that
would allow HHS to impose financial penalties on Washington unauthorized by

1 the statutes HHS invokes. The Final Rule’s enforcement scheme would permit
2 HHS to withhold or deny Washington federal funding amounting to billions of
3 dollars if OCR determines that it or one of its subrecipients failed to comply with
4 the Final Rule.

5 114. Absent injunctive and declaratory relief vacating the Final Rule and
6 prohibiting it from going into effect, Washington and its residents will be
7 immediately, continuously, and irreparably harmed by Defendants’ illegal
8 actions.

9 **Count II**
10 **Violation of the Administrative Procedure Act**
11 **Agency Action Not in Accordance with Law—Other Federal Laws**

12 115. The State realleges and reincorporates by reference the allegations
13 set forth in each of the preceding paragraphs.

14 116. The APA requires that agency action that is “not in accordance with
15 law” be held unlawful and set aside. 5 U.S.C. § 706(2).

16 117. Section 1554 of the ACA provides that the HHS Secretary “shall not
17 promulgate any regulation” that “creates any unreasonable barriers to the ability
18 of individuals to obtain appropriate medical care”; “impedes timely access to
19 health care services”; “interferes with communications regarding a full range of
20 treatment options between the patient and the provider”; “restricts the ability of
21 health care providers to provide full disclosure of all relevant information to
22 patients making health care decisions”; or “violates the principles of informed

1 consent and the ethical standards of health care professionals.” 42 U.S.C.
2 § 18114.

3 118. The Final Rule violates Section 1554 in numerous ways, including,
4 among other ways, by creating “unreasonable barriers to the ability of individuals
5 to obtain appropriate medical care” through the denial of counseling and referrals
6 and sanctioning delays and denials of medically indicated care; “impeding timely
7 access to health care services” by permitting delays in and denials of care
8 required by applicable medical standards; “interfer[ing] with communications
9 regarding a full range of treatment options between the patient and the provider”
10 by unlawfully authorizing the denial of counseling and referrals; “restrict[ing] the
11 ability of health care providers to provide full disclosure of all relevant
12 information to patients making health care decisions”; and “violat[ing] the
13 principles of informed consent and the ethical standards of health care
14 professionals” by permitting medical professionals to withhold medically
15 relevant information and violate medical ethical standards and other duties to
16 their patients recognized by leading medical authorities. 42 U.S.C. § 18114.

17 119. The Final Rule violates the contraceptive coverage requirement in
18 the ACA, 42 U.S.C. § 300gg-13(a)(4), with regard to non-exempt employers with
19 religious beliefs that conflict with the use of contraceptives, by creating an
20 absolute refusal right that conflicts with the accommodation created by HHS’s
21 own regulations.
22

1 120. The Final Rule violates EMTALA by allowing hospitals to assert a
2 categorical objection to providing patients requiring certain services with a
3 medical screening examination and, if the patient has an “emergency medical
4 condition,” stabilizing treatment or providing an appropriate transfer. 42 U.S.C.
5 § 1395dd; 42 C.F.R § 489.24.

6 121. The Final Rule violates the Non-Directive Mandate in annual
7 appropriations acts applicable to HHS requiring that all pregnancy counseling
8 within a Title X program be nondirective. *See* Pub. L. No. 115-245 (Sept. 28,
9 2018). The Final Rule violates the Non-Directive Mandate by purporting to
10 permit objecting providers in Washington to refuse to ensure that patients
11 determined to be pregnant receive information on all available options without
12 promoting, advocating, or encouraging one option over another.

13 122. The Final Rule violates Title VII of the Civil Rights Act of 1964,
14 42 U.S.C. § 2000e(j), by eliminating the “undue hardship” exception for
15 employers who are required to accommodate employees’ religious beliefs and
16 avoid discrimination in employment based on religion.

17 123. Absent injunctive and declaratory relief vacating the Final Rule and
18 prohibiting it from going into effect, Washington and its residents will be
19 immediately, continuously, and irreparably harmed by Defendants’ illegal
20 actions.

21
22

1 **Count III**
2 **Violation of the Administrative Procedure Act**
3 **Arbitrary and Capricious Agency Action**

4 124. The State realleges and reincorporates by reference the allegations
5 set forth in each of the preceding paragraphs.

6 125. The Final Rule is arbitrary and capricious in numerous respects. It
7 reverses the Department's longstanding policies and interpretations of Title X
8 with no evidentiary basis or cogent rationale, requires deviation from
9 evidence-backed standards of care and medical ethical and fiduciary obligations,
10 needlessly jeopardizes patients' lives, health, and well-being, disregards and/or
11 is contrary to evidence before the agency, ignores many important aspects of the
12 problem and the significant new problems it will create, relies on factors
13 Congress did not intend the agency to consider, and is illogical and
14 counterproductive.

15 126. One or more of these problems affects virtually every new provision
16 of the Final Rule, rendering the Final Rule arbitrary and capricious in its entirety.

17 127. Absent injunctive and declaratory relief vacating the Final Rule and
18 prohibiting it from going into effect, Washington and its residents will be
19 immediately, continuously, and irreparably harmed by Defendants' illegal
20 actions.

21 **Count IV**
22 **Violation of the Spending Clause**

128. The State realleges and reincorporates by reference the allegations
set forth in each of the preceding paragraphs.

1 129. Article I, section 8, clause 1 of the United States Constitution, also
2 known as the Spending Clause, states that “Congress shall have power to lay and
3 collect taxes, duties, imposts and excises, to pay the debts and provide for the
4 common defense and general welfare of the United States.”

5 130. The Final Rule violates the Spending Clause because the restrictions
6 are unconstitutionally coercive, do not provide the State with adequate notice of
7 what action or conduct will result in a withholding of federal health care funds,
8 and impose sanctions that are not rationally related to the underlying federal
9 programs.

10 131. When conditions on the payment to state or local governments of
11 specific federal funds “take the form of threats to terminate other significant
12 independent grants, the conditions are properly viewed as a means of pressuring
13 the States to accept policy changes.” *Nat’l Fed. of Indep. Bus. v. Sebelius*,
14 567 U.S. 519, 580 (2012). Here, the Final Rule threatens to terminate or withhold
15 billions of dollars of healthcare federal funding that the State would otherwise
16 receive, and in so doing, imposes conditions that “cross[] the line distinguishing
17 encouragement from coercion.” *Id.* at 579. The Department’s threat to withhold
18 or deny billions of dollars of healthcare funds, including funds unrelated to
19 healthcare, is “much more than ‘relatively mild encouragement’—it is a gun to
20 the head.” *Id.* at 581. A threat of this magnitude leaves the State “with no real
21 option but to acquiesce” to the federal requirement. *Id.* at 582.

22

1 136. The United States Constitution exclusively grants the spending
2 power to Congress. U.S. Const. art. 1, § 8, cl. 1. Congress may delegate some
3 discretion to the Executive Branch, but the Executive Branch is not allowed to
4 amend or cancel Congressional appropriations.

5 137. The Final Rule permits Defendants to refuse to disburse money
6 appropriated by Congress, thereby violating constitutional separation of powers
7 principles.

8 138. Absent injunctive and declaratory relief vacating the Final Rule and
9 prohibiting it from going into effect, Washington and its residents will be
10 immediately, continuously, and irreparably harmed by Defendants' illegal
11 actions.

12 **Count VII**
Violation of the Establishment Clause

13 139. The State realleges and reincorporates by reference the allegations
14 set forth in each of the preceding paragraphs.

15 140. Under the Establishment Clause of the First Amendment, the
16 “[g]overnment in our democracy, state and national, must be neutral in matters
17 of religio[n].” *Epperson v. Arkansas*, 393 U.S. 97, 103 (1968). The government
18 “may not aid, foster, or promote one religion or religious theory against another,”
19 *id.*, nor “religion over irreligion,” *McCreary Cty. v. ACLU of Kentucky*,
20 545 U.S. 844, 875 (2005). “When the government acts with the ostensible and
21 predominant purpose of advancing religion, it violates that central Establishment
22

1 Clause value of official religious neutrality” *Id.* at 860. The government also
2 violates the Establishment Clause where it imposes an “absolute duty” on
3 employers to “conform their business practices to the particular religious
4 practices of [an] employee,” such that “religious concerns automatically control
5 over all secular interests at the workplace.” *Estate of Thornton v. Caldor, Inc.*,
6 472 U.S. 703, 709 (1985).

7 141. The Final Rule has the predominant purpose and effect of
8 advancing, endorsing, and elevating individual health care workers’ religious
9 beliefs above all other interests—including patients’ health, welfare, and choices
10 (whether religious or secular). In doing so, the Final Rule imposes an absolute
11 duty on medical providers—including state-operated entities—to accommodate
12 employees’ asserted religious beliefs no matter what burdens doing so would
13 impose on the providers, other employees, or patients. In promulgating the Final
14 Rule, HHS has put its thumb on the scale to favor some religious beliefs over
15 other beliefs, telling “nonadherents ‘that they are outsiders, not full members of
16 the political community, and . . . adherents that they are insiders, favored
17 members of the political community.’” *Santa Fe Indep. Sch. Dist. v. Doe*,
18 530 U.S. 290, 309–10 (2000).

19 142. The Final Rule violates the Establishment Clause, causing harm to
20 Washington’s sovereign and proprietary interests, and to its residents.
21
22

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

VI. PRAYER FOR RELIEF

Wherefore, the State of Washington prays that the Court:

- a. Declare that the Final Rule is unauthorized by and contrary to the Constitution and laws of the United States;
- b. Declare that the Final Rule is invalid and without force of law and vacate the Final Rule in full;
- c. Issue preliminary and permanent injunctions prohibiting Defendants from implementing or enforcing the Final Rule;
- d. Award the State of Washington its costs and reasonable attorneys’ fees; and
- e. Award such other and further relief as the interests of justice may require.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

RESPECTFULLY SUBMITTED this 28th day of May 2019.

ROBERT W. FERGUSON
Attorney General

JEFFREY T. SPRUNG, WSBA #23607
MARTHA RODRÍGUEZ LÓPEZ, WSBA #35466
ZACHARY P. JONES, WSBA #44557
JEFFREY C. GRANT, WSBA #11046
R. JULY SIMPSON, WSBA #45869
Assistant Attorneys General
Office of the Attorney General
800 Fifth Avenue, Suite 2000
Seattle, WA 98104
(206) 464-7744
Jeff.Sprung@atg.wa.gov
Martha.RodriguezLopez@atg.wa.gov
Zach.Jones@atg.wa.gov
Jeffrey.Grant@atg.wa.gov
July.Simpson@atg.wa.gov
Attorneys for Plaintiff State of Washington