Nos. 19-431 & 19-454

In the Supreme Court of the United States

LITTLE SISTERS OF THE POOR
SAINTS PETER AND PAUL HOME, *Petitioner,*
v.
COMMONWEALTH OF PENNSYLVANIA
AND STATE OF NEW JERSEY, *Respondents.*

DONALD J. TRUMP, PRESIDENT OF
THE UNITED STATES, ET AL., *Petitioners,*
v.
COMMONWEALTH OF PENNSYLVANIA
AND STATE OF NEW JERSEY, *Respondents.*

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF OF MASSACHUSETTS, CALIFORNIA, COLORADO, CONNECTICUT, DELAWARE, THE DISTRICT OF COLUMBIA, HAWAI'I, ILLINOIS, MAINE, MARYLAND, MICHIGAN, MINNESOTA, NEVADA, NEW MEXICO, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA, AND WASHINGTON AS *AMICI CURIAE* IN SUPPORT OF PENNSYLVANIA AND NEW JERSEY

XAVIER BECERRA, *Attorney General of California*
MICHAEL J. MONGAN
Solicitor General
AIMEE FEINBERG
Deputy Solicitor General
KATHLEEN BOERGERS
Supervising Deputy Attorney General
KARLI EISENBERG
Deputy Attorney General
KRISTIN A. LISKA
Associate Deputy Solicitor General
1300 I Street, Suite 125
Sacramento, CA 94244

MAURA HEALEY, *Attorney General of Massachusetts*
ELIZABETH N. DEWAR*
State Solicitor
JULIA E. KOBICK
JON BURKE
Assistant Attorneys General
One Ashburton Place
Boston, MA 02108
(617) 963-2204
bessie.dewar@mass.gov
**Counsel of Record*

(Additional counsel are listed on signature pages.)

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Constitutional Provisions and Statutes

Regulations

Miscellaneous

INTERESTS OF *AMICI CURIAE*

The *Amici* States—Massachusetts, California, Colorado, Connecticut, Delaware, the District of Columbia, Hawai'i, Illinois, Maine, Maryland, Michigan, Minnesota, Nevada, New Mexico, New York, North Carolina, Oregon, Rhode Island, Vermont, Virginia, and Washington—have compelling interests in protecting the health, wellbeing, and economic security of our residents. To promote these interests, the *Amici* States are committed to ensuring a robust regulatory regime that makes the full range of Food and Drug Administration-approved contraception widely available and affordable for women and families. Access to contraception advances educational opportunity, workplace equality, and financial empowerment for women; improves the health of women and children; and reduces healthcare-related costs for individuals, families, and the States.

For these reasons, the *Amici* States have long pursued policies to expand access to contraception. Many *Amici* States have enacted laws that require certain insurance plans to cover contraception, expanded access to contraceptives under Medicaid, and implemented family planning programs to provide subsidized contraceptive services to low-income residents.[1] But states can only go so far on their own. Federal law preempts state regulation of

[1] *See* Guttmacher Institute, *Insurance Coverage of Contraceptives* (Apr. 1, 2020), https://tinyurl.com/ul3wa4q.

self-insured employer health plans, which cover most employees and their dependents nationwide.[2]

The Women's Health Amendment to the Patient Protection and Affordable Act ("ACA"), 42 U.S.C. § 300gg-13(a)(4), fills the resulting gap. As implemented through the Women's Preventive Services Guidelines, the Amendment guarantees contraceptive coverage without cost-sharing to women nationwide, including the millions of women covered by insurance plans that federal law places beyond the reach of state regulation. The *Amici* States therefore have a strong interest in ensuring that the Women's Health Amendment is implemented and enforced in a way that achieves Congress's goals of full and equal coverage for women and that thereby also avoids imposing unjustifiable costs on the States.

SUMMARY OF THE ARGUMENT

Congress adopted the Women's Health Amendment to ensure that women's preventive healthcare needs receive "full and equal health coverage." *Zubik v. Burwell*, 136 S. Ct. 1557, 1660 (2016) (*per curiam*) (internal quotation marks omitted). The Amendment—as implemented through the Women's Preventive Services Guidelines—mandates that certain health plans provide contraceptive care and services without cost-sharing. The Amendment also fills a gap in coverage that

[2] *See* U.S. Dep't of Health & Human Servs., Medical Expenditure Panel Survey, Table II.B.2.b.(1): *Percent of Private-Sector Enrollees That Are Enrolled in Self-Insured Plans at Establishments That Offer Health Insurance by Firm Size and State: United States, 2018* (2020), https://tinyurl.com/vrcmbsr.

predated the ACA: Because the federal Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1144(a), (b)(2)(A), preempts state regulation of self-insured employer-sponsored health plans, state laws that mandate contraceptive coverage could not reach women insured by these plans. In the years since establishment of the nationwide contraceptive mandate, the country has made great strides in expanding access to the most effective forms of contraception for women and in reducing overall expenditures on contraception.

Rather than honor Congress's commitment to provide women with full and equal healthcare, the U.S. Departments of Health and Human Services, Labor, and the Treasury ("the Departments") have issued two Final Rules that create blanket exemptions to the ACA's contraceptive mandate for virtually any employer with religious or moral objections to contraception. *See* 83 Fed. Reg. 57592, 57613-25 (Nov. 15, 2018); 83 Fed. Reg. 57536, 57556-73 (Nov. 15, 2018). These exemptions, which are of national scope, make women's access to contraceptive coverage contingent on the religious and moral approval of their employers. The Final Rules are thus contrary to both the text and purpose of the Women's Health Amendment. And the legislative history further confirms that Congress did not provide the agencies with authority to promulgate the moral and religious exemption rules; Congress itself rejected a "conscience amendment."

These unauthorized Final Rules will harm tens of thousands of women—and will also force states to assume the costs of replacement contraception and

medical care for unintended pregnancies. The economic harm to states will cross state lines, as women who receive health insurance from out-of-state employers, or who remain on their parents' out-of-state health plans, seek contraception and care in the states in which they live.

Having correctly determined that the Final Rules were likely unlawfully promulgated and inconsistent with the ACA, the district court acted well within its discretion in granting a preliminary injunction to bar implementation of the rules nationwide pending final adjudication of the case on the merits. District courts have the flexibility and discretion to craft injunctive relief suitable for the facts of the case at hand. In this case, because the economic effects of the Final Rules will transcend state borders as women cross state lines for work and school, the scope of the injunction is no more burdensome to the Departments than necessary to give Pennsylvania and New Jersey complete relief. The scope of the injunction is also tailored to the scope of the Departments' legal violations and accords with the remedies for unlawful agency action authorized by Congress in the Administrative Procedure Act.

ARGUMENT

I. The Women's Health Amendment Guarantees Women Full and Equal Health Coverage.

The Women's Health Amendment to the Affordable Care Act, 42 U.S.C. § 300gg-13(a)(4), guarantees that women nationwide receive full and equal coverage for preventive health services, including contraception.

The provision was intended to secure equal treatment and benefits by requiring that health plans cover comprehensive "preventive care and screenings" for women. 42 U.S.C. § 300gg-13(a)(4). The Final Rules, which create blanket nationwide exemptions from that mandate, flout Congress's aims and jeopardize the health gains made by women since the ACA's enactment.

A. Congress Intended for Women to Have Full and Equal Coverage for Preventive Health Care.

One of the ACA's central reforms is the requirement that employer-sponsored health plans include coverage for a broad range of preventive medical services on a no-cost basis, meaning that plan participants cannot be charged cost-sharing payments like copayments or deductibles. *See* 42 U.S.C. § 300gg-13(a). As part of this reform, the Women's Health Amendment was enacted to ensure that women's preventive care needs, in particular, were covered.

As originally drafted, coverage for preventive care for adults under the statute would have been based primarily on existing recommendations from a longstanding independent body called the United States Preventive Services Task Force ("USPSTF").[3] *See* H.R. 3590, § 1001 (S. Amdt. 2786, Nov. 19, 2009) (proposing Sec. 2713). And, indeed, under the law as enacted, USPSTF recommendations do form the basis for part of the ACA's multifaceted preventive care

[3] *See* U.S. Preventive Servs. Task Force, *About the USPSTF* (Mar. 2019), https://tinyurl.com/sejrbk7.

mandate. *See* 42 U.S.C. § 300gg-13(a)(1). Congress recognized, however, that structuring the preventive services requirement solely around USPSTF's recommendations would have left women underinsured. Although the USPSTF's recommendations were evidence based, they were also "modeled on men's health needs." *Priests for Life v. U.S. Dep't of Health & Human Servs.*, 772 F.3d 229, 235 (D.C. Cir. 2014), *vacated sub nom. Zubik v. Burwell*, 136 S. Ct. 1557 (2016); *see also* 155 Cong. Rec. S12042 (Dec. 1, 2009) (Sen. Harkin) (discussing longstanding concerns "that the task force has not spent enough time studying preventive services that are unique to women"). In particular, because the USPSTF recommendations failed to incorporate input from "women's health advocates and medical professionals," they did not require coverage for a number of "critically important" preventive services for women, including "family planning services." 155 Cong. Rec. S12025 (Dec. 1, 2009) (Sen. Boxer). As a result, the original bill was inadequate to meet "the unique preventive health needs of women." *Id.*; *see also* 78 Fed. Reg. 39870, 39873 (July 2, 2013) (the ACA "acknowledges that both existing health coverage and existing preventive services recommendations often did not adequately serve the unique health needs of women").

Congress's solution was the Women's Health Amendment, a provision that mandates coverage of preventive services specifically for women. *See* 42 U.S.C. § 300gg-13(a)(4). The Amendment's sponsors understood that many states had existing laws that required some degree of coverage for women's preventive services, including contraception. *See* 155

Cong. Rec. S12026 (Dec. 1, 2009) (Sen. Mikulski). Indeed, over the prior two decades, state contraceptive coverage requirements had significantly increased access to affordable contraception.[4] But, as women's health experts stressed, a nationwide, federal guarantee was necessary to supplement state-level protections, for at least two reasons. First, millions of women lived in states with limited coverage requirements or no coverage requirements at all.[5] And second, even in those states with coverage requirements, ERISA preempted enforcement of any state requirements against self-insured employer health plans, which cover more than half of all Americans. *See* 29 U.S.C. §§ 1144(a), (b)(2)(A).[6]

Congress was therefore unwilling to leave women's access to preventive healthcare dependent on "State mandates." *See* 155 Cong. Rec. S12026 (Dec. 1, 2009) (Sen. Mikulski). As enacted, the Women's Health Amendment (1) "requires" health plans to provide no-cost coverage for women's preventive care and services; and (2) assigns the Health Resources and Services Administration ("HRSA")—an agency within the U.S. Department of Health and Human Services ("HHS")—responsibility for "specify[ing] what types of preventive care must be covered." *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 697 (2014). Congress selected HRSA for this task because its expertise in

---

[4] *See* A. Sonfield et al., *U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Coverage Mandates, 2002*, 36 PERSPECTIVES ON SEXUAL & REPRODUCTIVE HEALTH 72, 76 (March-April 2004), https://tinyurl.com/sl93sbq.

[5] *See* Sonfield et al., *supra* note 4, at 73.

[6] *See* Sonfield et al., *supra* note 4, at 72-73.

women's health and preventive medicine would enable it to develop evidence-based guidelines for women's preventive care services. *See* 155 Cong. Rec. S12058-59 (Dec. 1, 2009) (Sen. Cardin).

While authorizing HRSA to determine "*which* preventive services to require" for women, *Hobby Lobby*, 573 U.S. at 697 (emphasis added), Congress also made clear that HRSA's guidelines must be developed "for purposes of" the Women's Health Amendment. 42 U.S.C. § 300gg-13(a)(4). That textual command requires HRSA to respect the purposes for which the Amendment was enacted. As the Departments have previously explained to this Court, chief among those purposes was "[t]o ensure that women receive full and equal health coverage appropriate to their medical needs." Brief of Respondents 5, *Zubik v. Burwell*, 136 S. Ct. 1557 (2016) (No. 14-1418) ("*Zubik* Br."). Congress wanted to "see to it that women are treated equally, and particularly in preventive care." 155 Cong. Rec. S12030 (Dec. 1, 2009) (Sen. Dodd).

In line with that purpose, Congress also sought to redress the discriminatory practice of charging women more for preventive services than men. *See* 155 Cong. Rec. S12027 (Dec. 1, 2009) (Sen. Gillibrand) ("women of child-bearing age spend 68 percent more in out-of-pocket heath care costs than men"). Before the ACA, "more than half of women delay[ed] or avoid[ed] preventive care because of its cost." *Id.* Thus, even though women and men were paying into the same employer-sponsored health plan, "women in the workforce [were] at a disadvantage compared to their male co-workers." 77 Fed. Reg. 8725, 8728 (Feb. 15,

2012). The Women's Health Amendment's requirement of no-cost coverage for a "comprehensive" range of women's preventive health services was written to eliminate these disparities. 42 U.S.C. § 300gg-13(a)(4).

B. The Final Rules Are Inconsistent with the Amendment's Guarantee of Full and Equal Coverage.

The Final Rules' sweeping exemptions for employers with religious or moral objections to contraception contravene Congress's mandate in the Women's Health Amendment that women receive full and equal coverage for preventive health care services. Indeed, Congress has specifically rejected exemptions of these kinds.

When it enacted the Women's Health Amendment, Congress understood that contraceptive care and services are an essential component of women's healthcare, but one that had been left out of the USPSTF's recommendations. *See, e.g.*, 155 Cong. Rec. S12027 (Dec. 1, 2009) (Sen. Shaheen) ("Women must have access to vitally important preventive services such as . . . preconception counseling that promotes healthier pregnancies and optimal birth outcomes."). And members of Congress repeatedly emphasized that the "comprehensive" coverage required by the Amendment, as implemented through HRSA's guidelines, would necessarily include contraceptive care and services. *See, e.g.*, 155 Cong. Rec. S12027 (Dec. 1, 2009) (Sen. Gillibrand) (under the Amendment, "even more preventive screening[s] will be covered, including for . . . family planning"); 155

Cong. Rec. S12114 (Dec. 2, 2009) (Sen. Feinstein) ("The amendment . . . will require insurance plans to cover at no cost basic preventive services and screenings for women," including "family planning."); 155 Cong. Rec. S12274 (Dec. 3, 2009) (Sen. Murray) (the "amendment will make sure this bill provides coverage for important preventive services for women at no cost," including "family planning services"); *id.* at S12277 (Sen. Nelson) ("I strongly support the underlying goal of furthering preventive care for women, including . . . family planning."); 155 Cong. Rec. S12671 (Dec. 8, 2009) (Sen. Durbin) (the Amendment would guarantee access to "affordable birth control and contraceptive services" and lead to "more counseling, more contraception, and fewer unintended pregnancies").[7]

In August 2012, HRSA adopted the Women's Preventive Services Guidelines, which require employers to provide "coverage without cost sharing," for "[a]ll Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with

---

[7] As the Amendment's sponsor further explained, the preventive services for women were intended to "be based on the benefit package available to Federal employees. It means if our amendment passes, the women of America will have the same access to preventive and screening services as the women of Congress," who at the time had access to all Food and Drug Administration-approved contraceptives. 155 Cong. Rec. S12026 (Dec. 1, 2009) (Sen. Mikulski); *accord id.* at S12042 (Sen. Harkin) ("By voting for this amendment . . . we can ensure all women will have access to the same baseline set of comprehensive preventive benefits that Members of Congress and those in the Federal Employee Health Benefits Program currently enjoy.").

reproductive capacity" (hereinafter "the contraceptive mandate").[8] These Guidelines were informed by a lengthy study by a 16-member committee of experts convened by the Institute of Medicine to consider "what preventive services are necessary for women's health and well-being."[9] The committee concluded that access to contraception reduces the risk of unintended pregnancies, adverse pregnancy outcomes, and other negative health consequences for women and children.[10] And by enhancing women's ability to control their reproductive health, including the timing and spacing of pregnancy, contraception gives women the power to choose if and how they pursue educational, employment, and other opportunities.[11] In turn, access to contraception improves public health and contributes to the growth of states' economies.[12]

---

[8] Health Resources & Servs. Admin., *Women's Preventive Services Guidelines* (Dec. 2019), https://www.hrsa.gov/womens-guidelines/index.html.

[9] Institute of Medicine, CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS 2 (2011), https://tinyurl.com/rhy9j6f (hereinafter "IOM Report").

[10] IOM Report, *supra* note 9, at 103, 105-07.

[11] *See* A. Sonfield et al., *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children*, GUTTMACHER INSTITUTE (Mar. 2013), https://tinyurl.com/sulelqz; *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 856 (1992) (plurality op.) (access to contraception is essential for "women to participate equally in the economic and social life of the Nation").

[12] *See* 78 Fed. Reg. at 39872-73.

In 2012, after HRSA had adopted the Guidelines, some members of Congress introduced a bill to insert a "conscience amendment" into the ACA. 158 Cong. Rec. S538-39 (Feb. 9, 2012) (S. Amdt. 1520). As a proponent of the amendment recounted, original drafts of the ACA had included a "conscience protection" that would have authorized religious and moral exemptions to the statute's coverage requirements, but the provision "was taken out of the [ACA] . . . [before it] was passed." 158 Cong. Rec. S1116 (Feb. 29, 2012) (Sen. Johanns). The sponsor of the 2012 proposal explained that his bill would authorize employers to deny coverage for preventive services based on their religious or moral convictions. 158 Cong. Rec. S1115 (Feb. 29, 2012) (Sen. Blunt). Although the proposed amendment was drafted to apply generally to all services and procedures covered by the ACA, *see* 158 Cong. Rec. S538-39 (Feb. 9, 2012) (S. Amdt. 1520, § (b)(1)), it was first and foremost directed at the contraceptive coverage mandate. *See, e.g.*, 158 Cong. Rec. S1162 (Mar. 1, 2012) (Sen. Vitter); *id.* at S1164 (Sen. Hatch).

Shortly after this bill was introduced, the Departments issued rules creating a limited exemption for houses of worship and their integrated auxiliaries from the contraceptive mandate and announced plans to create an "accommodation" for non-profit religious employers. *See* 77 Fed. Reg. 8725 (Feb. 15, 2012).[13] Subsequent congressional debates

[13] As the Departments later explained to this Court, the limited exemption for houses of worship is based upon "longstanding governmental recognition of a particular sphere of autonomy for houses of worship" under the First Amendment, *Zubik* Br. at 67-68 (internal quotation marks omitted), and

addressed the new houses-of-worship exemption and proposed accommodation, emphasizing a key intended effect of the proposed conscience amendment: to allow *any* employer—not just houses of worship—to refuse to provide contraceptive coverage based on religious belief or moral conviction. *See, e.g.*, 158 Cong. Rec. S1162 (Mar. 1, 2012) (Sen. Vitter).

Congress voted down the conscience amendment bill soon after, 158 Cong. Rec. D170 (Mar. 1, 2012), thus reaffirming that it did not intend for a woman's access to contraception to be contingent upon the religious or moral approval of her employer. *See* 158 Cong. Rec. S1106 (Feb. 29, 2012) (Sen. Gillibrand). And Congress likewise rejected the idea that the limited exemption for houses of worship should be extended to "any insurer or employer." *Id.*

Thus, the Departments' Final Rules rewrite the ACA in ways Congress repeatedly rejected: in 2010, when it excluded a conscience provision from the ACA, and again in 2012, when it voted down the conscience amendment bill. By exempting nearly any entity with a religious or moral objection to contraception from the contraceptive mandate, the rules threaten the gains made possible by the ACA. At present, more than 46 million women receive comprehensive, no-cost coverage for contraceptive care and services through an employer-sponsored plan. *See* 82 Fed. Reg. 47792, 47821 (Oct. 13, 2017). Since Congress enacted the ACA and HRSA issued the Guidelines, out-of-pocket

---

defines "houses of worship" consistent with a similar longstanding exemption in the Internal Revenue Code. *See* 76 Fed. Reg. 46621, 46623, 46626 (Aug. 3, 2011).

expenditures for contraception have fallen by more than 70%. *Id*. at 47805. Use of more effective forms of contraception, such as intrauterine devices, has increased significantly.[14] And many states have seen a significant decrease in the number of women without contraceptive coverage seeking care through state-funded programs.[15] The Final Rules imperil these important advances and defy Congress's commitment to provide women with full and equal access to preventive healthcare.

II. The Loss of Full and Equal Health Coverage Will Harm Women and Impose Economic Burdens on the States.

The Final Rules will cause tens of thousands of women nationwide to lose the comprehensive contraceptive coverage guaranteed by the Women's Health Amendment and the Guidelines—coverage Congress intended to extend to women nationwide, no matter in which state she lives. And because of ERISA preemption, the rules effectively eliminate *all* protections, federal and state alike, for women who receive coverage through self-insured employer health plans. For these women, access to contraceptive

---

[14] *See* A. Snyder et al., *The Impact of the Affordable Care Act on Contraceptive Use and Costs Among Privately Insured Women*, 28 WOMEN'S HEALTH ISSUES 219-23 (May-June 2018), https://tinyurl.com/w4xvdmo.

[15] *See, e.g.*, J. Frost et al., *Contraceptive Needs and Services, 2014 Update* 9 (Sept. 2016), https://tinyurl.com/wcp7jgf ("As a result [of implementation of the ACA], the numbers of women in need of publicly funded contraceptive care who were uninsured fell dramatically between 2010 and 2014.").

coverage will depend on their employers' religious beliefs or moral convictions.

The widespread loss of coverage will not only injure women nationwide, but also harm the States. Many women who lose coverage because of the rules will obtain replacement contraception through state-funded programs. Other women—those who are unable to obtain replacement contraceptives or who obtain less effective methods—may experience unintended pregnancies that impose additional costs on states. Both within and across state borders, the rules will upend reproductive health gains for women made possible by the ACA.

A. The Rules Will Cause Thousands of Women to Lose Contraceptive Coverage.

The record establishes that employers will use the exemptions adopted by the rules and that, as a consequence, women across the country will lose contraceptive coverage. Indeed, at each stage in the rulemaking process, the Departments conceded as much. According to their regulatory impact analysis, approximately three million people receive health insurance through employers and universities that have already asserted religious objections to providing coverage for contraceptive care and services under the ACA. 83 Fed. Reg. at 57575-78. Of these millions, the Departments estimate, between 70,500 and 126,400 women of childbearing age will lose contraceptive coverage. 83 Fed. Reg. at 57578, 57580; 83 Fed. Reg. at 57627-28. These estimates include only "women whose contraceptive costs will be impacted by the

expanded exemption[s] in th[e] final rules." 83 Fed. Reg. at 57578.

The Departments' loss-of-coverage estimates are based on two conservative methods of calculation. The upper-bound estimate—126,400 women—is based on nationwide survey data regarding the number of employers that excluded contraceptive coverage from their insurance plans before the ACA went into effect. *See* 83 Fed. Reg. at 57578-81; 82 Fed. Reg. at 47821-24. The Departments use this data to estimate the number employers that will use the rules' expanded exemptions. *Id.* Notably, the Departments assume that only a small fraction of the women who were denied contraceptive coverage prior to the ACA will lose coverage as a result of the rules. *Id*. Nothing in this survey data, or in the administrative record, suggests that women living in any particular state will be unaffected by the rules. *See id.*

The Departments' lower-bound estimate—70,500 women—is based on the number of employers and universities that previously raised religious objections to the provision of contraceptive coverage under the ACA, by either suing the Departments ("litigating employers") or using the existing accommodation ("accommodated employers"). *See* 83 Fed. Reg. at 57575-78; 82 Fed. Reg. at 47815-21. The administrative record identifies the litigating employers that, according to the Departments, will use the expanded religious exemption. *See* Brief of *Amici Curiae* Massachusetts et al., *Pennsylvania v. Trump*, No. 2:17-cv-04540, ECF No. 113-1, Exhibit A, at 669264-70 (E.D. Pa. Jan. 7, 2019) (administrative record excerpt; hereinafter "Ex. A, Admin. Rec.").

These litigating employers are in virtually every state, including in Pennsylvania, New Jersey, and the *Amici* States. *See id.* Collectively, they employ or enroll hundreds of thousands of people across the country, many of whom also have dependents receiving insurance through these plans. *See id.* The Departments estimate that, of those individuals who work for the litigating employers, 6,400 will be women of childbearing age who use a form of contraception covered by the Guidelines. 83 Fed. Reg. at 57577-78.

The administrative record also identifies many of the accommodated employers. *See* Ex. A, Admin. Rec. at 670107-33. Although the Departments' data are incomplete,[16] they estimate that 209 employers are using the accommodation. *See* 83 Fed. Reg. at 57576; 82 Fed. Reg. at 47817-18. This figure is taken from an estimate that HHS originally made in 2014, *id.*, and that was subsequently characterized as "likely [an] underestimate," 80 Fed. Reg. 41318, 41332 (July 14, 2015).[17] The Departments assume that 109 of these 209 accommodated employers will use the expanded

---

[16] Under prior regulations, employers were not required to provide notice to the Departments in order to use the accommodation, and many did not do so. *See* 83 Fed. Reg. at 57576; 82 Fed. Reg. at 47817-18.

[17] The Departments cited uncertainty about this estimate—as well as uncertainty concerning the number of employers that will use the moral exemption rule—as bases for including the upper-bound estimate in the analysis. *See* 83 Fed. Reg. at 57578, 57628. Unlike the lower bound, the upper-bound estimate accounts, to some extent, for the likelihood that employers other than those who have already objected to providing contraception coverage will use the expanded exemptions. *See* 83 Fed. Reg. at 57578-81.

exemptions. 83 Fed. Reg. at 57577-78. And they further estimate that, of those individuals employed by the 109 accommodated employers, 64,000 will be women of childbearing age who use a form of contraception covered by the Guidelines. *Id.* Thus, under either method of calculating regulatory impact, tens of thousands of women will lose contraceptive coverage because of the rules.[18]

The contraceptive equity laws that exist in some states cannot eliminate this loss of coverage. With respect to the lower-bound estimate, the Departments expect that 63% of women who work for accommodated employers and who lose coverage because of the rules have self-insured plans exempt from state regulation due to ERISA preemption. *See* 83 Fed. Reg. at 57577. And the upper-bound estimate already excludes women protected by state contraceptive equity laws; the survey data underlying that estimate were collected in 2010, after 29 states

[18] In arriving at their estimates, the Departments adjusted for a host of factors that could affect employers' use of the expanded exemptions. For example, they took into account the fact that some objecting employers will continue to use the ACA's existing accommodation—which provides alternative coverage for contraception—rather than the expanded exemptions, *see, e.g.*, 83 Fed. Reg. at 57575, 82 Fed. Reg. at 47818; that some employers are covered by injunctions exempting them from the contraceptive mandate, 83 Fed. Reg. at 57575-76, 82 Fed. Reg. at 47818; and that some employers that use the expanded exemptions will object to covering only certain contraceptive methods, 83 Fed. Reg. at 57581, 82 Fed. Reg. at 47823.

had already enacted such laws.[19] State contraceptive equity laws cannot, therefore, protect these women.

B. Many Women Who Lose Contraceptive Coverage Because of the Rules Will Obtain Replacement Contraceptive Care from State-Funded Programs or Seek State-Funded Medical Care for Unintended Pregnancies.

When women lose the contraceptive coverage previously included in their health plans, they still need contraceptive care and services. The record in this case establishes that many of these women will turn to state-funded programs for replacement contraception or for medical care for unintended pregnancies. This, in turn, will impose significant economic burdens on the States.

The States will experience immediate economic harm as women who lose coverage seek replacement contraceptive care from state-funded programs. On average, contraception costs $584 per year per woman. 83 Fed. Reg. at 57578. Consequently, the Departments expect that it will cost between $41.2 and $67.3 million annually to provide replacement contraceptive care for all the women who will lose coverage because of the rules. 83 Fed. Reg. at 57578, 57581. As the Departments recognize, states will bear a significant share of this cost. *See* 82 Fed. Reg. at 47803 (downplaying the rules' impact by noting that "there are multiple Federal, State, and local programs that provide free or subsidized contraceptives for low-

[19] *See* IOM Report, *supra* note 9, at 51.

income women"); *Massachusetts v. U.S. Dep't of Health & Human Servs.*, 923 F.3d 209, 226 (1st Cir. 2019) ("[T]he Departments have assumed in their own regulatory impact analysis that 'state and local governments will bear additional economic costs.'" (quoting *California v. Azar*, 911 F.3d 558, 572 (9th Cir. 2018))).

Many women who lose contraceptive coverage but otherwise retain the balance of their insurance will be income-eligible for contraceptive care under state programs. Federal law mandates that state Medicaid programs provide coverage for family planning services. *See* 42 U.S.C. § 1396d(a)(4)(C).[20] And access to coverage through employer-sponsored insurance generally does not make women ineligible for state-funded Medicaid, Medicaid Family Planning Expansion, and Title X/State Family Planning programs, particularly where coverage has been declined by the employer. Among the *Amici* States, eligibility limits for the programs extend up to 300% of the federal poverty level, with many such programs falling in the range of 200% to 250% of the federal poverty level.[21] With the 2020 poverty level set at

---

[20] *See also* IOM Report, *supra* note 9, at 61 ("Since 1972, state Medicaid programs have been required to cover family planning services and supplies furnished . . . to individuals of childbearing age . . . who are eligible under the State plan, and who desire such services and supplies." (internal quotation marks omitted)).

[21] *See, e.g.*, *Massachusetts*, 923 F.3d at 218 (discussing state-funded programs in Massachusetts); T. Brooks et al., *Medicaid and CHIP Eligibility, Enrollment, and Cost-Sharing Policies as of January 2020: Findings from a 50-State Survey*, KAISER FAMILY FOUND., Tables 1 & 3 (Mar. 26, 2020), https://tinyurl.com/vgh3xgb; Guttmacher Institute, *Medicaid*

$21,720 for a family of three, $26,200 for a family of four, and higher for larger families, *see* 85 Fed. Reg. 3060 (Jan. 17, 2020), many women earning more than $50,000 per year, and some women earning over $75,000 per year, will be eligible. *See Massachusetts*, 923 F.3d at 226 (noting evidence that, "on average, about twenty-five percent of women . . . who currently have employer-sponsored coverage could qualify for these state-funded programs").

Overall, in the Plaintiff and *Amici* States, there are more than 4.3 million women of childbearing age who are income-eligible for a state-funded program and who receive health insurance through an employer-based plan that is not subject to any state-imposed contraceptive mandate.[22] And the *Amici* States' experience confirms that women who cannot use

---

Family Planning Eligibility Expansions (Apr. 1, 2020), https://tinyurl.com/rltxbcq.

[22] This figure provides a conservative estimate of the number of women between the ages of 15 and 45 who are eligible for a broadly available state-funded program such as Medicaid, Medicaid Family Planning Expansion, or Title X/State Family Planning and are not protected by a state contraceptive coverage law. It does not include women who are eligible for state-funded assistance making cost-sharing payments chargeable under a state-specific contraceptive coverage law or women who may be eligible for programs that are available only to a relatively narrow class of residents, such as the Children's Health Insurance Program. *See supra*, note 21. The estimate is based on data available through the Interactive Public Use Microdata Series, which provides detailed data from the U.S. Census Bureau's American Community Survey (2015); the State Health Access Data Assistance Center; and the Agency for Healthcare Research and Quality. *See* S. Ruggles et al., IPUMS USA: Version 9.0 Dataset (2019), https://doi.org/10.18128/D010.V9.0.

existing healthcare coverage, especially for reproductive health needs, do routinely seek coverage from state-funded programs. In Massachusetts, for example, the Commonwealth's Medicaid program already covers more than 150,000 residents who also have commercial insurance. *Massachusetts*, 923 F.3d at 218. For these women, there will be no need to seek out state-funded care if their employer terminates contraceptive coverage; they will automatically receive state-funded replacement coverage.

Most of the women who lose coverage as a result of the Final Rules will, however, experience significant disruptions in their access to contraceptive care. These women may need to seek out different healthcare providers for their contraceptive needs, paying out of pocket or applying for state programs for which they may be eligible. In the process, these women may lose access to their trusted provider and may need to arrange to transfer medical records. A single provider can take into account all of a woman's medical needs and provide holistic advice on which family planning methods best suit those needs. But requiring women to seek out new providers, or to coordinate between multiple providers, can impede timely and effective access to contraceptive care. *See, e.g.*, 78 Fed. Reg. at 39888 ("Imposing additional barriers to women receiving the intended coverage (and its attendant benefits) . . . would make that coverage accessible to fewer women.").

These disruptions will reduce use of contraception and cause a corresponding increase in unintended pregnancies. *See* 83 Fed. Reg. at 57585 & n.123 (acknowledging that a "noteworthy" potential effect of

the Final Rules will be an increase in spending on "pregnancy-related medical services"). The evidence underpinning the contraceptive mandate shows that even minor obstacles can deter use of contraception. *See, e.g.*, 78 Fed. Reg. at 39888. For this reason, it was critical that "[u]nder the accommodation" previously embraced by the Departments, "female employees . . . would continue to face minimal logistical and administrative obstacles," *Hobby Lobby*, 573 U.S. at 732 (internal quotation marks omitted), because they "would still receive the *same* insurance coverage from the *same* insurer for contraceptives," *Priests for Life v. U.S. Dep't of Health & Human Servs.*, 808 F.3d 1, 24-25 (D.C. Cir. 2015) (Kavanaugh, J., dissenting from denial of rehearing en banc) (emphasis in original). The blanket exemptions adopted by the Final Rules, in contrast, will "impede women's receipt of benefits by requiring them to take steps to learn about, and to sign up for" care with different providers or different insurance plans. *Hobby Lobby*, 573 U.S. at 732 (internal quotation marks and brackets omitted).

The States will not be insulated from the increased costs associated with unintended pregnancies simply because women who lose contraceptive coverage may retain the balance of coverage provided by their employer-sponsored health plans. Increased healthcare costs will be passed on to the States through Medicaid and other programs that provide wraparound coverage and reimbursement for deductibles, co-insurance, emergency care, and other services not covered by primary insurance.[23] These

[23] *See, e.g.*, 130 Code Mass. Regs. 450.317 (wraparound insurance regulations for Massachusetts' Medicaid program).

costs are significant: the average employer-sponsored plan has an annual deductible of $1,573 for individuals and, depending on the plan, up to $4,527 for families, and most plans impose additional cost-sharing fees for emergency room and hospital care.[24] States, which already spend billions of dollars annually on unintended pregnancies,[25] will thus assume many costs associated with the unintended pregnancies of women who lose coverage because of the rules. *See Massachusetts*, 923 F.3d at 225 (recognizing that the rules will result in states incurring costs for "prenatal care for unintended pregnancies").

C. The Economic Injuries to the States Will Transcend State Boundaries.

The economic injuries inflicted by the Final Rules will not only occur in every state, but also will cross the borders between states. Thus, even the partial measures a state may take to mitigate the damage caused by the rules—for example, a state contraceptive mandate, from which all self-insured plans would be exempt—are of limited use in protecting that state's residents and forestalling financial injury.

---

[24] *See* Kaiser Family Found., EMPLOYER HEALTH BENEFITS: 2018 ANNUAL SURVEY 103, 114 (2018), https://tinyurl.com/y4xwt5n8.

[25] *See* A. Sonfield et al., *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, GUTTMACHER INSTITUTE (Feb. 2015), https://tinyurl.com/wz4yjf5.

The interstate nature of the injury reflects the interconnectedness of our national economy. Millions of employees and their dependents receive health insurance through employers located in one state, but live or receive healthcare in a different state. For example, workers today often commute to or telework[26] for employers located outside their home state. Recent research has shown that national employment and commuting patterns are more meaningfully represented through "mega-regions" that span state boundaries than by state borders.[27] While interstate commuting is concentrated within these regions, census data also shows that significant numbers of employees, including telecommuters, work for employers located outside of neighboring states.[28]

---

[26] *See, e.g.*, U.S. Dep't of Labor, Bureau of Labor Statistics, *24 Percent of Employed People Did Some or All of Their Work at Home in 2015*, THE ECONOMICS DAILY (July 8, 2016), https://tinyurl.com/mylwkr4.

[27] *See* G. Nelson & A. Rae, *An Economic Geography of the United States: From Commutes to Megaregions*, PLOS One (Nov. 30, 2016), https://tinyurl.com/qq5cl22; A. Swanson & J. O'Connell, *What the U.S. Map Should Really Look Like*, WASH. POST (Dec. 12, 2016), https://tinyurl.com/w24s3eb.

[28] *See* U.S. Census Bureau Longitudinal Employer-Household Program, *Origin-Destination Employment Statistics* (2017) (data accessible at https://tinyurl.com/s5wzkrk) (hereinafter "Census Bureau, *Origin-Destination Employment Statistics*"); *see also* U.S. Census Bureau, *Out-of-State and Long Commutes: 2011*, AMERICAN COMMUNITY SURVEY REPORTS, at 10 & Table 6 (Feb. 2013), https://tinyurl.com/y2ftyn3w.

Overall, in the Plaintiff and *Amici* States, more than 4.1 million residents commute to work out of state.[29]

In addition to commuting workers, hundreds of thousands of students attend out-of-state colleges and universities each year, including more than 256,000 in the Plaintiff and *Amici* States.[30] Most of these students continue to receive health insurance coverage as dependents on their parents' employer-sponsored plans.[31] Indeed, nationally, nearly 14 million people under the age of 26—including both students and non-students—remain on their parents' health plans.[32]

As these examples illustrate, the harms caused by the rules will spread unconfined by state boundaries, as commuters, remote workers, and dependents lose coverage and seek replacement care where their healthcare provider—not their employer—is located. The injuries threatened by the Final Rules to the

---

[29] *See* Census Bureau, *Origin-Destination Employment Statistics*, *supra* note 28.

[30] *See* Nat'l Ctr. for Education Statistics, *Residence and Migration of All First-Time Degree/Certificate-Seeking Undergraduates*, DIGEST OF EDUCATION STATISTICS (2017), https://tinyurl.com/s7malmg.

[31] *See, e.g.*, U.S. Gov't Accountability Office, *Health Insurance: Most College Students Are Covered Through Employer-Sponsored Plans, and Some Colleges and States Are Taking Steps to Increase Coverage*, at 10 (Mar. 2008), https://tinyurl.com/schbttw.

[32] *See, e.g.*, S. Rollins et al., *Young, Uninsured and in Debt: Why Young Adults Lack Health Insurance and How the Affordable Care Act Is Helping*, THE COMMONWEALTH FUND, at 2 (June 2012), https://tinyurl.com/sznav79.

Plaintiff and *Amici* States and their residents are thus both pervasive and untethered to state borders: reaching women in every State, and reaching many of them from across state lines.

III. The Preliminary Injunction Entered in This Case Is Necessary to Prevent Harm to the Plaintiff States.

Given the scope of the injury threatened by the Final Rules, and the interstate nature of that injury, the district court did not abuse its discretion in temporarily enjoining the rules on a nationwide basis. The district court carefully weighed the harm to the Plaintiff States, the interests of the Departments, and the public interest in fashioning an equitable remedy. And it properly determined that, in the particular circumstances presented by this case, an injunction preventing enforcement of the Final Rules nationwide was necessary to afford Pennsylvania and New Jersey complete relief from the injuries inflicted on them by the rules.

A. District Courts Have Broad Equitable Authority to Tailor Injunctive Relief to the Particular Circumstances of a Case.

To come within a federal court's Article III jurisdiction, "a plaintiff must demonstrate standing for each claim [it] seeks to press and for each form of relief that is sought," whether in the form of damages, injunctive relief, or declaratory relief. *Town of Chester v. Laroe Estates, Inc.*, 137 S. Ct. 1645, 1650 (2017) (quoting *Davis v. FEC*, 554 U.S. 724, 734 (2008)). But once a plaintiff has established standing to press its

claims and request injunctive relief, as Pennsylvania and New Jersey have done here, Article III imposes no further restraint on the *scope* of equitable relief that a district court may order. Instead, "the extent to which equity will go to give relief where there is no adequate remedy at law" rests "in the sound discretion of the court." *Virginian Ry. Co. v. Sys. Fed'n No. 40*, 300 U.S. 515, 551 (1937).

This Court has explained that "[c]rafting a preliminary injunction is an exercise of discretion and judgment" that reflects the "equities of a given case" and the "substance of the legal issues it presents." *Trump v. Int'l Refugee Assistance Project*, 137 S. Ct. 2080, 2087 (2017) ("*IRAP*") (*per curiam*). A court's equitable powers, which "assume an even broader and more flexible character" when "federal law is at issue and the public interest is involved," *Kansas v. Nebraska*, 574 U.S. 445, 456 (2015) (internal quotation marks omitted), have never been "a matter of fixed rule." *Virginian Ry. Co.*, 300 U.S. at 551. Thus, in each case, the court "must balance the competing claims of injury and must consider the effect on each party of the granting or withholding of the requested relief." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 24 (2008) (internal quotation marks omitted). And "[i]n awarding a preliminary injunction a court must also consider the overall public interest." *IRAP*, 137 S. Ct. at 2087 (internal quotation marks, alterations, and ellipses omitted).[33]

---

[33] The discretion afforded district courts in crafting the scope of equitable relief is reflected in the abuse-of-discretion standard of review. *See eBay v. MercExchange, L.L.C.*, 547 U.S. 388, 391, 394 (2006) ("[T]he decision whether to grant or deny injunctive

While recognizing the breadth of district courts' equitable discretion to issue injunctive relief, this Court has also established guideposts for courts' exercise of that discretion. In general, "injunctive relief should be no more burdensome to the defendant than necessary to provide complete relief to the plaintiffs." *Madsen v. Women's Health Ctr., Inc.*, 512 U.S. 753, 765 (1994) (quoting *Califano v. Yamasaki*, 442 U.S. 682, 702 (1979)). And the scope of any injunction must be informed by the scope of the legal violation. *See Milliken v. Bradley*, 433 U.S. 267, 280 (1977). Furthermore, where Congress concludes that particular situations call for more limited remedies, it may limit the scope of equitable authority by statute. *See Porter v. Warner Holding Co.*, 328 U.S. 395, 398 (1946) ("Unless a statute in so many words, or by a necessary and inescapable inference, restricts the court's jurisdiction in equity, the full scope of that jurisdiction is to be recognized and applied."). Ultimately, the "essence" of the authority to issue injunctive relief is "the power . . . to do equity and to mould each decree to the necessities of the particular case. Flexibility rather than rigidity has distinguished it." *Hecht Co. v. Bowles*, 321 U.S. 321, 329 (1944).

---

relief rests within the equitable discretion of the district courts," and that "act of equitable discretion" is only "reviewable on appeal for abuse of discretion."). "[D]eference," of course, "is the hallmark of abuse-of-discretion review." *General Elec. Co. v. Joiner*, 522 U.S. 136, 143 (1997).

B. The District Court Did Not Abuse Its Discretion in Enjoining the Rules on a Nationwide Basis During the Pendency of the Litigation.

Application of these principles demonstrates that the preliminary injunction issued in this case was well within the district court's equitable discretion. A temporary measure tailored to the scope of the legal violations, the injunction gives Pennsylvania and New Jersey complete interim relief and prevents administrability problems inherent in a narrower remedy. The injunction also accords with Congress's approval of nationwide relief against unlawful agency actions, as reflected in the Administrative Procedure Act ("APA"), 5 U.S.C. §§ 705, 706(2).

Enjoining enforcement of the rules nationwide is necessary to redress the irreparable economic injuries they inflict on Pennsylvania and New Jersey. As the courts below recognized, hundreds of thousands of Pennsylvania and New Jersey residents travel each day to out-of-state jobs but may access state-funded contraceptive care within the Plaintiff States' borders. *See Pennsylvania v. President United States*, 930 F.3d 543, 576 (3d Cir. 2019); *Pennsylvania v. Trump*, 351 F. Supp. 3d 791, 833 (E.D. Pa. 2019). Indeed, as of 2017, approximately 707,000 New Jersey residents, or 16.6% of the workforce, and approximately 421,500 Pennsylvania residents, or 7.2% of the workforce, commuted out of state.[34] Thus, some of the Pennsylvania and New Jersey women who will lose

[34] Census Bureau, *Origin-Destination Employment Statistics, supra* note 28.

contraceptive coverage because of the rules will likely work for out-of-state employers, but nevertheless obtain state-funded replacement care in the states in which they reside.

The Departments' attempt to minimize the scope of these extraterritorial impacts falls flat. *See* Departments' Br. 47-48. It is not speculation that hundreds of thousands of New Jersey and Pennsylvania residents have employer-sponsored health plans from out-of-state employers; that data comes directly from the U.S. Census Bureau. *See supra*, note 28. And the Departments are wrong to suggest that most New Jersey residents who work out-of-state do so in Pennsylvania, and vice versa. *See* Departments' Br. 48. Rather, the Census Bureau data shows that more than 815,000 residents of the Plaintiff States work in states *other than* New Jersey and Pennsylvania.[35] These Pennsylvania and New Jersey residents work for employers located in states across the country, including all 21 of the *Amici* States.[36] And even though some of these residents work in states with contraceptive equity laws, Pennsylvania and New Jersey will still incur economic harm because of the prevalence of self-insured employer plans that are exempt from state regulation. *See California*, 911 F.3d at 573 ("Evidence shows that millions of people are covered, in [California,

---

[35] Census Bureau, *Origin-Destination Employment Statistics, supra* note 28.

[36] *See* Census Bureau, *Origin-Destination Employment Statistics, supra* note 28; *see also* U.S. Census Bureau, *Residence State-to-Workplace State Commuting Flows: 2011*, Appendix A, at 7-8 (Feb. 2013), https://tinyurl.com/uklxo5q.

Delaware, Maryland, and New York], under self-insured plans.").

Pennsylvania and New Jersey will also incur economic costs when out-of-state students who lose contraceptive coverage turn to state-funded programs for replacement care and services. Each year, colleges and universities in Pennsylvania and New Jersey take in more than 36,000 first-time out-of-state students.[37] As discussed above, many of these out-of-state students continue to receive health insurance as dependents on their parents' employer-based plans.[38] Thus, some of the women who will lose contraceptive coverage will remain on their parents' out-of-state plans, but obtain state-funded replacement care in the Plaintiff States, where they live and attend school. The Departments' conspicuous failure to address this source of cross-border injury, together with their failed effort to downplay the rules' other cross-border effects, underscores that the district court acted within its discretion in determining that enjoining enforcement of the rules nationwide was necessary to provide "complete relief to the plaintiffs." *Califano*, 442 U.S. at 702.

The Departments also overlook the second part of the inquiry, which focuses on how burdensome the injunctive relief is to the defendant. *See Madsen*, 512 U.S. at 765; *Califano*, 442 U.S. at 702. Under the particular circumstances of this case, a more limited injunction would be *more* burdensome to the Departments than an injunction that applies

---

[37] *See* Nat'l Ctr. for Education Statistics, *supra* note 30.

[38] *See* U.S. Gov't Accountability Office, *supra* note 31, at 10.

nationwide. To provide the Plaintiff States complete relief from harms threatened by the rules, a limited injunction would have to account for the aforementioned cross-border effects; enjoining enforcement of the rules only as to employers physically located in the Plaintiff States would be inadequate. Any limited injunction would thus necessarily involve sorting employers based in part on where their employees, as well as their employees' dependents, lived, attended school, or were otherwise likely to receive healthcare. Compliance with such an injunction would be highly burdensome for the Departments because, under the rules, the Departments have no ability to identify which employers are making use of exemptions in the first place. *See* 83 Fed. Reg. at 57588 (employers that use the exemptions need not provide notice to the Departments). A preliminary injunction preventing enforcement of the rules across the country while the litigation continues, in contrast, imposes no administrability burdens on the Departments and simply delays implementation of the rules until the case is resolved on the merits.

For similar reasons, the scope of the preliminary injunction in this case befits the expansive nature of the unlawful agency action here: rules creating nationwide exemptions to a federal statute. *See Califano*, 442 U.S. at 702; *Milliken*, 433 U.S. at 280. By design, the Final Rules eschew the "case-by-case consideration of religious exemptions to generally applicable rules" required by the Religious Freedom Restoration Act. *Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal*, 546 U.S. 418, 436 (2006). Instead, they adopt blanket exemptions for for-

profit entities, non-profit entities, insurers, and universities that have any religious or moral objection to contraception. *See* 83 Fed. Reg. at 57537; 83 Fed. Reg. at 57593. Consequently, the rules inflict harm on women on a nationwide basis—thus causing the cross-border harms to Pennsylvania and New Jersey just discussed—and the breadth of that harm is properly reflected in the scope of the district court's injunction. *See Dayton Bd. of Educ. v. Brinkman*, 433 U.S. 406, 420 (1977) (where "there has been a systemwide impact [there may be] a systemwide remedy").

And the propriety of the district court's preliminary injunction is underscored by the APA's statutory scheme. In the APA, Congress did not limit the scope of federal courts' equitable authority to enjoin unlawful agency actions on a nationwide basis. Quite the contrary: Congress expressly authorized district courts to hold agency actions unlawful in their entirety and to prohibit nationwide enforcement or implementation of an agency action. The APA empowers federal courts, prior to review of the lawfulness of a regulation on the merits, to "postpone the effective date of an agency action" pending conclusion of the proceedings, if "necessary to prevent irreparable injury." 5 U.S.C. § 705. Such relief inherently covers all applications of the challenged regulation, not only the application of the regulation to the plaintiffs. The APA also establishes that, upon reaching the merits, federal courts can "set aside" unlawful rules in their entirety, not only as applied to the plaintiffs. 5 U.S.C. § 706(2). Accordingly, it has long been held that "when a reviewing court determines that agency regulations are unlawful, the ordinary result is that the rules are vacated—not that

their application to the individual petitioners is proscribed." *Nat'l Mining Ass'n v. U.S. Army Corps of Eng'rs*, 145 F.3d 1399, 1409 (D.C. Cir. 1998) (quoting *Harmon v. Thornburgh*, 878 F.2d 484, 495 n.21 (D.C. Cir. 1989)). The district court thus properly recognized that its remedy—a preliminary injunction that temporarily delayed implementation of the Final Rules altogether pending adjudication on the merits—was in harmony with the statutory remedies prescribed by Congress. *See Pennsylvania*, 351 F. Supp. 3d at 831.

CONCLUSION

The Court should affirm the judgment of the court of appeals.

Respectfully submitted,

XAVIER BECERRA, *Attorney General of California*
MICHAEL J. MONGAN
Solicitor General
AIMEE FEINBERG
Deputy Solicitor General
KATHLEEN BOERGERS
Supervising Deputy Attorney General
KARLI EISENBERG
Deputy Attorney General
KRISTIN A. LISKA
Associate Deputy Solicitor General
1300 I Street, Suite 125
Sacramento, CA 94244

MAURA HEALEY,
Attorney General of Massachusetts
ELIZABETH N. DEWAR*
State Solicitor
JULIA E. KOBICK
JON BURKE
Assistant Attorneys General
One Ashburton Place
Boston, MA 02108
(617) 963-2204
bessie.dewar@mass.gov
**Counsel of Record*

April 8, 2020

PHILIP J. WEISER
Attorney General of Colorado
1300 Broadway
10th Floor
Denver, CO 80203

WILLIAM TONG
Attorney General of Connecticut
55 Elm Street
Hartford, CT 06106

KATHLEEN JENNINGS
Attorney General of Delaware
Department of Justice
Carvel State Building
6th Floor
820 North French Street
Wilmington, DE 19801

KARL A. RACINE
Attorney General for the District of Columbia
One Judiciary Square
441 4th Street, NW
Suite 630 South
Washington, D.C. 20001

CLARE E. CONNORS
Attorney General of Hawai'i
425 Queen Street
Honolulu, HI 96813

KWAME RAOUL
Attorney General of Illinois
100 West Randolph Street
Chicago, IL 60601

AARON M. FREY
Attorney General of Maine
6 State House Station
Augusta, ME 04333

BRIAN E. FROSH
Attorney General of Maryland
200 Saint Paul Place
Baltimore, MD 21202

DANA NESSEL
Attorney General of Michigan
P.O. Box 30212
Lansing, MI 48909

KEITH ELLISON
Attorney General of Minnesota
102 State Capitol
75 Rev. Dr. Martin Luther King Jr. Boulevard
St. Paul, MN 55155

AARON D. FORD
Attorney General of Nevada
100 North Carson Street
Carson City, NV 89701

HECTOR BALDERAS
Attorney General of New Mexico
408 Galisteo Street
Santa Fe, NM 87501

LETITIA JAMES
Attorney General of New York
28 Liberty Street
New York, NY 10005

JOSHUA H. STEIN
Attorney General of North Carolina
North Carolina
Department of Justice
114 W. Edenton Street
Raleigh, NC 27603

ELLEN F. ROSENBLUM
Attorney General of Oregon
1162 Court Street N.E.
Salem, OR 97301

PETER F. NERONHA
Attorney General of Rhode Island
150 South Main Street
Providence, RI 02903

THOMAS J. DONOVAN, JR.
Attorney General of Vermont
109 State Street
Montpelier, VT 05609

MARK R. HERRING
Attorney General of Virginia
202 North 9th Street
Richmond, VA 23219

ROBERT W. FERGUSON
Attorney General of Washington
P.O. Box 40100
Olympia, WA 98504