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UNITED STATES DISTRICT COURT

DISTRICT OF OREGON

EUGENE DIVISION

STATE OF OREGON, et al., Plaintiffs, v. ALEX M. AZAR II, in his official capacity as Secretary of Health and Human Services, et al., Defendants.	Case No. 6:19-cv-00317-MC PLAINTIFF STATES' REPLY IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION Pursuant to Fed. R. Civ. P. 65 and 5 U.S.C. § 705

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I. Introduction

Reading defendants' (collectively "HHS") brief, one would believe nothing of relevance to this case has occurred in the last 28 years since *Rust v. Sullivan*, 500 U.S. 173 (1991), was decided, and that *Rust* authoritatively resolved all the issues before the Court. Not so. *Rust* merely held that § 1008 of Title X was "ambiguous," and that the 1988 rules, which were similar to the Final Rule here, were a "plausible" construction of ambiguous statutory terms, 500 U.S. at 184. That decision does not control this case because, since *Rust*, Congress has constrained the agency's authority to promulgate *Rust*-like regulations. Since 1996, Congress has included the Nondirective Mandate in each statutory appropriations bill, requiring all medically appropriate information be presented to pregnant women, without suggesting or advising one option over another. The Final Rule would limit information available to patients and require instead directive counseling, including referrals, in favor of childbirth. Congress's preference for patient choice and autonomy is confirmed by § 1554 of the Affordable Care Act ("ACA"), 42 U.S.C. § 18114, which expressly bars HHS from limiting the full disclosure of all relevant information to patients making health care decisions. The Final Rule is contrary to both the Nondirective Mandate and the ACA.

Nor is the record before the Court the same record that was before the courts in 1991. HHS's abrupt change of course in the Final Rule is unsupported by the anything in the administrative record in 2019 and is arbitrary and capricious. The plaintiff States therefore have made a compelling showing on the merits and their irreparable injury in undisputed—the dozens of declarations filed by the States demonstrating injuries to the public health and state finances are not countered by any evidence from HHS. Based on this evidence and strong public interest

in the rule of law and in federal agencies complying with the APA, the States are entitled to preliminary injunctive relief.

II. Argument

A. Plaintiffs are likely to succeed on the merits.

1. Rust does not control.

Contrary to HHS's contentions, the States do not seek to overrule *Rust*. *Rust* simply does not speak to the issues raised in this case. HHS treats *Rust* as a talisman that insulates it from challenge to any Title X rules (indeed, HHS mentions *Rust* 168 separate times in its brief), but *Rust* did not definitively construe any statutory provision in Title X. It did not determine that Congress intended to gag Title X providers or to require physical separation between Title X-funded health care and abortion referrals or materials. Rather, the Court found the language of § 1008 to be ambiguous in that § 1008 "does not speak directly to the issues of counseling, referral, advocacy, or program integrity." 500 U.S. at 184. It then held that the statute "allows the Secretary's construction of the statute" and that HHS's 1988 construction of the statute was not "impermissible." *Id*. For that reason, the Court deferred to the agency's construction. *Id*.

For these reasons alone, HHS's insistence that *Rust* "mandates" physical separation or that *Rust* contains a "'clear, authoritative judicial holding on the meaning of a particular provision'" must be rejected. (*See, e.g.*, Opp'n Br., Apr. 11, 2019, Doc. 90 ("Opp.") at 15, 18).[1] *Rust* did no such thing. Nor, relatedly, is there any issue about an implied repeal of § 1008. (Opp. at 17-19). Because the Court did not definitively interpret § 1008 or any other provision of Title X, there is no issue of a repeal or a conflict between statutory provisions. But Congress *has* changed the legal landscape since *Rust* was decided. In the Nondirective Mandate and the

[1] Page number citations are to the ECF assigned page numbers.

ACA, Congress limited HHS's authority to enact regulations under § 1008. Ambiguities in § 1008 may have given HHS the discretion upheld in *Rust*, but later-enacted law has restrained its exercise. *Rust* does not control the States' contrary-to-law claims.

Rust is similarly not dispositive of the arbitrary and capricious or the procedural APA claims. Whereas HHS supported the 1988 regulations with first-hand survey results from Title X providers and beneficiaries collected by the General Accounting Office ("GAO") and the HHS Office of the Inspector General ("OIG"), the Final Rule in this case is justified by no comparable research, and instead is based primarily on unsupported summary conclusions. *See* *Rust*, 500 U.S. at 188-89 (the gag requirements were not arbitrary and capricious because HHS, "in the wake of the critical reports of the [GAO] and [OIG]," determined that providers needed additional guidance on "how to preserve the distinction between Title X programs and abortion as a method of family planning"; separation requirement was not arbitrary and capricious because it was "promulgated in direct response to the observations in the GAO and OIG reports").

HHS cannot simply dust off a 30-year-old record as justification for its radical change in policy and ignore everything that has happened in the interim. Yet that is effectively what HHS attempts to do. (Opp. at 31-32). HHS now has decades of data showing the program to be an overwhelming success: providers are no longer confused, if they ever were, about what constitutes permissible nondirective counseling[2] and are closely monitored to ensure that family

[2] AMA Ltr. 2; ACOG Ltr. 6; AAN Ltr. 4; Guttmacher Ltr. 7-8; Loretta Gavin, Susan Moskosky, et al., Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs, Morbidity and Mortality Weekly Report, 63 Recommendations and Reports No. 4, 13-14 (Apr. 25, 2014) ("QFP"); *see* Pl. States' Mem. of Law in Supp. of Mot. For Prelim. Inj. (filed Mar. 21, 2019), Doc. 35 ("States' Mem.") at 11.

planning and abortion-related activities are segregated.[3] *Rust* does not relieve HHS from the obligation, under the APA, to provide a reasonable explanation for its actions at the time of the agency's decision. *See* *Sierra Club v. E.P.A.*, 671 F.3d 955, 966 (9th Cir. 2012); *Dow AgroSciences LLC v. Nat'l Marine Fisheries Serv.*, 707 F.3d 462, 473 (4th Cir. 2013) (agency action was arbitrary and capricious where the agency "recognized that it was relying on outdated data and that it had been presented with more recent data, but it chose to continue relying on the outdated data without explaining why").

2. The Final Rule is not in accordance with law.

a. The Nondirective Mandate bars the Final Rule.

The first statutory enactment since *Rust* was the Nondirective Mandate. HHS argues that the Final Rule complies with the Nondirective Mandate because it permits what it calls "nondirective counseling" by certain health care providers, even though that counseling cannot include referrals for abortion care. Referrals, HHS explains, are completely different and separate from nondirective counseling. HHS is wrong.

The meaning of the Nondirective Mandate is clear. Both Congress and HHS have expressly recognized that referrals are part of nondirective pregnancy counseling.[4] In 2000, Congress created an HHS program to provide "adoption information and referrals to pregnant women *on an equal basis with all other courses of action included in nondirective counseling to*

[3] Angela Napili, Cong. Research Serv., RL 33644, *Title X (Public Health Service Act) Family Planning Program* at 22 (Aug. 31, 2017); Angela Napili, Cong. Research Serv., R 45181, *Family Planning Program under Title X of the Public Health Service Act* 14 (Apr. 27, 2018); WA Ltr. 17-19; NY Ltr. 4-6; CA Ltr. 19-20; *see* States' Mem. 28-29.

[4] HHS's reliance upon Black's Law Dictionary is similarly unavailing. Nothing about the generic definition of "referral" suggests that it does not fit comfortably within the definition of "counseling." (Opp. at 21-22). In any event, there is no need to resort to dictionary definitions when both Congress and HHS have spoken and when the governing agency's own clinical guidelines are clear and consistent.

pregnant women." 42 U.S.C. § 254c-6(a)(1), (a)(2)(B)(ii) (emphasis added). The 2000 statute was an amendment to the Public Health Service Act ("PHSA"), which is the same Act containing Title X. *See* Pub. L. 106-310, Div. A, Title XII, § 1201, Oct. 17, 2000, 114 Stat. 1101. In the Final Rule, HHS acknowledged both that the 2000 amendments to the PHSA apply to Title X clinics and that referrals are a part of nondirective counseling: Congress "express[ed] its intent that postconception adoption information and referrals be included as part of any nondirective counseling in Title X projects." 84 Fed. Reg. 7714, 7730 (Mar. 4, 2019); *see also id.* at 7733-34 (suggesting that counseling and referral on adoption as part of postconception counseling is "consistent with the Title X parameters and with the Department's history of implementing Title X"); *id.* at 7744 (noting that providers "may provide adoption information and referrals during postconception pregnancy counseling as long as the pregnancy counseling satisfies the statutory requirement that it be nondirective").[5] This accords with clinical guidelines developed by the office administering Title X as well as clinical practice.[6]

HHS also argues that Congress did not ratify HHS's interpretation of Title X as embodied in the 2000 regulations by appropriating funds and, even if it did, HHS is free to change that interpretation. (Opp. at 20-21). HHS misses the mark. The point is not simply that Congress ratified the 2000 rules by continuing to appropriate funds for the program. The point is that it

[5] HHS explained in the Final Rule that it could not disallow nondirective counseling entirely because, in addition to enacting the Nondirective Mandate, Congress "directed the Department to include 'nondirective counseling to pregnant women'" in 42 U.S.C. § 254c-6. *See* 84 Fed. Reg. 7745. The Nondirective Mandate, then, is not the only statute that requires Title X providers to offer nondirective pregnancy counseling.

[6] *See* Loretta Gavin, Susan Moskosky, et al., Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs, Morbidity and Mortality Weekly Report, 63 Recommendations and Reports No. 4, 13 (April 25, 2014) (discussing pregnancy testing, nondirective counseling, and referrals under the heading "Pregnancy Testing and Counseling"); Kost Decl. ¶ 25.

has expressly included language – the Nondirective Mandate – in each appropriations law since 1996 incorporating the former HHS interpretation into governing law. HHS also argues that the Court should apply a presumption against appropriations acts "substantively chang[ing] existing law." (Opp. at 19). But the Nondirective Mandate repeated in every appropriations law for more than two decades changed no substantive law at all; the Nondirective Mandate has been consistent with HHS's interpretation of Title X and its regulations for that entire period until now, clearing up the ambiguities the *Rust* court had found to allow a contrary interpretation.

Ultimately, the Final Rule turns the concept of nondirective counseling on its head. Rather than conforming to the agency's own clinical guidelines and allowing counseling to be directed by the wishes of the patient—which is what *real* nondirective counseling is—the Final Rule requires counseling to be directed by the political views of the agency. Indeed, HHS's Opposition doubles down on its position that pro-birth information be presented notwithstanding the Nondirective Mandate and regardless of the request of the patient. (Opp. at 35). For all the reasons described in the States' opening brief (States' Mem. at 18-22), the Final Rule contravenes the Nondirective Mandate.

b. The gag and separation requirements contravene the Affordable Care Act.

The second statutory enactment that was not before the Court in *Rust* was § 1554 of the Affordable Care Act ("ACA"). 42 U.S.C. § 18114. HHS offers no defense at all on the substance of § 1554. Rather, HHS argues that § 1554 does not apply to HHS's administration of Title X, that § 1554 is so broad that it is not enforceable, and that the States waived any claim concerning § 1554. These arguments fail.

HHS argues that it is not bound by § 1554 here because that statute is limited to HHS's administration of the ACA itself. HHS claims it is limited because the provision applies

"[n]otwithstanding any other provision of this Act." (Opp. at 28). But that phrase cannot be read to limit the provision to administration of the ACA. The phrase indicates only that the provision supersedes other provisions of the ACA that may be in conflict with it. The section by its terms generally limits HHS's authority to promulgate certain regulations: "Notwithstanding any other provision of this Act, the Secretary of Health and Human Services shall not promulgate *any* regulation[.]" 42 U.S.C. § 18114 (emphasis added). In contrast, Congress clearly limited the ACA's application in other respects. *See, e.g.*, 42 U.S.C. § 18118(a) ("Nothing in this title . . . shall be construed to modify, impair, or supersede the operation of any of the antitrust laws."). No comparable limit on the ACA provision's reach can reasonably be inferred from the language of § 1554. *See Barnhart v. Sigmon Coal Co., Inc.*, 534 U.S. 438, 452 (2002) ("[W]hen Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.") (internal quotation marks omitted).

HHS next argues that § 1554 does not apply because it involves the denial of benefits and § 1008, as well as the Final Rule, only addresses a funding issue. (Opp. at 27). But that argument is unsupported by the text of § 1554. Nothing in § 1554 suggests that it means something other than what it says, which is that the "Secretary of Health and Human Services shall not promulgate any regulation that," among other things, "restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions." 42 U.S.C. § 18114(4). That, among other things, is *exactly* what the Final Rule does by prohibiting all Title X providers from referring patients for abortion care. *See, e.g.*, 84 Fed. Reg. at 7787-88 (stating that Title X projects must "[n]ot provide, promote, refer for, or support

abortion as a method of family planning"). Nothing in the text of § 1554 limits its reach as HHS suggests.

HHS next contends that § 1554 is so "open-ended," "general," and "wholly undefined" that "it is inconceivable to imagine that Congress intended" to force HHS to comply. (Opp. at 28-29). HHS then argues that the States' claims are probably not "reviewable under the APA at all." (Opp. at 28). The narrow exception to judicial review under the APA that HHS invokes is not applicable here. It applies only when "the agency action of which plaintiff complains fails to raise a legal issue which can be reviewed by the court by reference to statutory standards and legislative intent." *Arizona Power Authority v. Morton*, 549 F.2d 1231, 1240 (9th Cir. 1977) (internal citations omitted). The provisions of § 1554 are clearly stated statutory standards that this Court can and should apply.

HHS also invokes a statutory construction maxim that can apply when specific statutes conflict with general statutes. (Opp. at 29). But that maxim does not apply here because § 1554 of the ACA does not conflict with § 1008 of Title X. Courts "must read the statutes to give effect to each if we can do so while preserving their sense and purpose." *Watt v. Alaska*, 451 U.S. 259, 267 (1981). Before issuing the Final Rule at issue here, HHS had no difficulty giving effect to both statutes.

Finally, HHS argues that the States waived any claim related to § 1554 by failing to identify that statutory section in comments on the proposed rule. But that argument also fails. First, statutory limits to the Department's regulatory authority are enforceable whether or not the statutory limit was expressly cited in written comment. *See Sierra Club v. Pruitt*, 293 F. Supp. 3d 1050, 1061 (N. D. Cal. 2018) ("[T]he waiver rule does not apply to preclude argument where the scope of the agency's power to act is concerned."). In other words, federal agencies are

required to comply with Acts of Congress whether or not commenters in a rulemaking remind agencies of their obligation to follow the law. Second, it is factually incorrect to assert that the rulemaking record does not reflect comments regarding the constraints on HHS's authority imposed by § 1554. Although the States are not aware of a specific citation to that statutory subsection in the rulemaking record, commenters did raise every *substantive issue* the States raise now under § 1554 without limitation.[7] That is sufficient to put the agency on notice. *See, e.g.*, *Lands Council v. McNair*, 629 F.3d 1070, 1076 (9th Cir. 2010) (commenters "need not raise an issue using precise legal formulations, as long as enough clarity is provided that the decision maker understands the issue raised. Accordingly, alerting the agency in general terms will be enough if the agency has been given "a chance to bring its expertise to bear to resolve [the] claim." (citation omitted)). Third, the Department was already demonstrably on notice of the limits of its authority given that HHS analyzed § 1554 in a separate rulemaking, also involving contraception and reproductive health, before it promulgated the Final Rule. *See* 83 Fed. Reg. 57536, 57552 (Nov. 15, 2018).

Each of HHS's arguments fails. For all the reasons cited in the States' Memorandum at 14-16—and entirely unrebutted by HHS—the Final Rule is contrary to § 1554.

3. The Final Rule is arbitrary and capricious in violation of the APA.

The States are also likely to prevail on their claim that the Final Rule is arbitrary and capricious. HHS relies primarily and extensively on *Rust* in response but those arguments fail because the record developed *here* does not support the Final Rule's abrupt reversal in policy.

[7] *See, e.g.*, CA Ltr. 4, 6 (barriers to care); Letter from Claire Brindis 3(access to services); Letter from Texas Policy Evaluation Project Investigators 1-5 (access to services); AAN Ltr. 4 (interference with patient communications); AMA Ltr. 1 (interference with patient communications); AMA Ltr. 1-2 (restricts full disclosure of relevant information); AAN Ltr. 4 (violates professional ethics of nurses); AMA Ltr. 1 (violates ethical obligations).

See supra II.A.1. HHS also makes a host of other arguments in no particular order, all of which also fail.

a. The gag requirements are arbitrary and capricious.

The Final Rule's gag requirements depart from HHS's settled interpretation of what constitutes permissible nondirective pregnancy counseling under § 1008 without supplying reasonable explanations. HHS's arguments to the contrary fail entirely to acknowledge that women have agency over their decision to get an abortion, and for those patients, mandatory prenatal referrals and prohibitions on referrals interfere with patient care and optimal health outcomes. HHS also did not provide meaningful responses to commenter concerns about the impact of new counseling and referral restrictions on the patient-provider relationship. While HHS referenced some of the commenters' objections, it dismissed these objections in summary conclusions without analysis, thus rendering the gag requirements invalid. *BNSF Ry. Co. v. Surface Transp. Bd.*, 741 F.3d 163, 168 (D.C. Cir. 2014) ("[A]n agency's failure to respond meaningfully to objections raised by a party renders its decision arbitrary and capricious.") (internal quotation marks omitted). HHS confuses mere acknowledgment of the crucial issues commenters raised in the Final Rule with meaningful response. (*See* Opp. at 44-45).

Mandatory prenatal care referrals: HHS fails to explain why the Final Rule mandates prenatal care referral for *all* pregnant patients. Prenatal care is neither necessary nor desirable for women who have decided to undergo an abortion. (*See* States' Mem. at 30-31). Notably, HHS does not address its prior determination in 2000 that mandatory referrals are "coercive" and inconsistent with the requirements of nondirective counseling. (*See* States' Mem. at 30). HHS also mischaracterizes the States' position as arguing that "prenatal care is unnecessary for women who obtain abortions" and responds that this "puts the cart before the horse" because, at

the time of the pregnancy counseling, "the patient has not yet *had* an abortion." (Opp. at 51 (emphasis in original); *cf.* States' Mem. at 31 (prenatal referrals are unnecessary for "women *seeking* abortions") (emphasis added)). HHS's response ultimately avoids explaining the reasons that HHS requires prenatal care referrals for patients who do not want or need them.

Prohibition on referrals for abortion: HHS's prohibition on referrals also fails to recognize that women, not clinicians providing nondirective counseling, decide whether to terminate their pregnancies. Again, HHS does not recognize women's agency for making their own health care decisions, characterizing the States' arguments as "difficult to fathom."[8] (*See* Opp. at 40). For decades, however, HHS has considered patient-driven referrals for any kind of follow-up care, whether for prenatal care or pregnancy termination, as part of nondirective counseling. The 2000 Regulations, which maintained HHS's commitment to circumscribing activities that "promoted or encouraged" abortion, expressly permit referrals. *See* 65 Fed. Reg. at 41270, 41273-74 (July 3, 2000). The Final Rule's ban on abortion referrals changes HHS's established interpretation of Section 1008 in the absence of adequate reasoning.

Accepting HHS's position that the dispute over whether referrals promote abortions is "beside the point" (*see* Opp. at 51), it is difficult to determine what other basis HHS had for concluding that referrals and the abortion procedure are "so linked that such a referral makes the Title X project or clinic a program one where abortion is a method of family planning." *See* 84 Fed. Reg. at 7717. Such a policy shift demands a more reasoned explanation. *See Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 41-42 (1983).

[8] Still, HHS does recognize that, before (and presumably since) 1988, it understood referrals as an activity "that did not have the immediate effect of promoting abortion, or the principal purpose or effect of promoting abortion." 84 Fed. Reg. at 7745 (discussing previous interpretations of § 1008).

No conflict exists between the current regulations and conscience statutes: Title X's facially neutral nondirective counseling requirements do not, and are not likely to, violate anti-discrimination statutes that protect religious objectors. The U.S. Department of Justice ("USDOJ") itself has previously reached the same conclusion. (*See* Br. for Defs. at *8-9, *California v. United States*, 2006 WL 1417044 (N.D. Cal.) (June 23, 2006) (USDOJ arguing that there was no "conflict between the Weldon Amendment and [California law] in regard to emergency abortions" because the state law "applies to medical emergencies involving any life-threatening or other serious condition, and not simply abortions, it does not on its face constitute discrimination within meaning of the Weldon Amendment").[9] The current 2000 regulations do not single out abortion for special treatment; clinicians must give, depending on patient preference, pregnancy counseling on *all* the options: prenatal care, abortion, and adoption.

Aside from the facial compatibility between the current regulations and conscience statutes, HHS has also removed any possibility that the two laws could conflict in the future by announcing affirmatively that it will not enforce Title X requirements against religious objectors. *See* 73 Fed. Reg. at 78087; *see also* Br. For Defs., *California v. United States*, 2006 WL 1417044, at *9 (dismissing as speculative the possibility that, one day, the statutes could conflict, particularly where there was no evidence that the state law had ever been enforced against religious objectors); *California v. United States*, No. 05 Civ. 00328 (JSW), 2008 WL 744840, at *5 (N.D. Cal. Mar. 18, 2008) (same). HHS's position that Title X's facially neutral rules – which, as far as the agency is aware, have never been enforced against religious objectors –

[9] *See also* *California v. United States*, 450 F.3d 436, 444 (9th Cir. 2006) (summarizing USDOJ's position as: "The Weldon Amendment does not reach statutes like [the California law] that do not facially discriminate against health care providers who refuse to provide abortion services. [The State law], after all, speaks in terms of health care providers that fail to provide *any* emergency service; it does not single out abortion for special treatment.").

"violate" or are "in tension with" anti-discrimination provisions of conscience statutes is thus unsupported by reasonable legal analysis. (*See* Opp. at 52-53).[10]

Limitations on pregnancy counseling to APPs: Although HHS is aware that non-APP staff currently provide a significant percentage of pregnancy counseling in Title X sites,[11] the Final Rule irrationally concluded that only APPs may counsel patients on pregnancy options. *See* 84 Fed. Reg. at 7761. In defense, HHS points out that the Proposed Rule limited certain forms of abortion counseling to doctors. (*See* Opp. at 51). As examples of "justifications" for this initial proposal, however, HHS references language from the Proposed Rule preamble that rephrases in several ways the agency's position on counseling – essentially, that doctors were permitted to give limited nondirective counseling on abortion.[12] *Id.* HHS came closest to an explanation when it singled doctors out, not for their specialized technical knowledge or skill, but for their ethical obligation to "promote patient safety." *See* 83 Fed. Reg. at 25507. Yet HHS also failed to acknowledge all medical professionals, no matter their educational credentials, have a duty to promote patient safety.[13]

Regardless, HHS's references to the Proposed Rule preamble do not shed light on the rationale for the Final Rule's restrictions. Whereas the Proposed Rule barred non-doctors from

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[10] Additionally, HHS's "belief" that the current rules may deter religious objectors from providing Title X services because they do not know that about the conscience protections in place is not based on any record evidence. (Opp. at 42). *See* *Nat'l Fuel Gas Supply Corp. v. F.E.R.C.*, 468 F.3d 831, 844 (D.C. Cir. 2006) (agency's conclusions must be supported by evidence in the record).

[11] *See* 83 Fed. Reg. 25502, 25507 (June 1, 2018).

[12] The Proposed Rule, in fact, did not even clearly permit doctors to give general abortion counseling. While the preamble mentioned a doctor's ability to give nondirective counseling on abortion, the Proposed Rule only permitted doctors to provide patients with a list of comprehensive primary health providers, some, but not the majority of which, could offer abortion services. *Cf.* 83 Fed. Reg. at 25507, 25518 *and* 83 Fed. Reg. at 25531.

[13] AAN Ltr. 4.

counseling on abortion, the Final Rule bars all non-APP staff from providing what HHS calls "nondirective pregnancy counseling." The Final Rule includes no discussion whatsoever of the reasoning behind the Department's decision. Arguing that it "reasonably drew the line at APPs," HHS cites one footnote from the Final Rule, which simply lists the types of nurses who qualify as APPs. (*See* Opp. at 51 (citing 84 Fed. Reg. at 7728 n.41)). HHS has not offered a sufficient basis for the restrictions on non-APP providers, who have long offered competent and cost-effective pregnancy counseling to patients.[14]

b. The separation requirement is arbitrary and capricious.

The separation requirement, which will cause large-scale disruption to the family planning program, seeks to solve a speculative putative problem. HHS essentially concedes that it is unaware of any instance in which Title X providers have misused program funds for abortion-related services, but emphasizes its ability to make prophylactic rules to avoid future misconduct. (*See* Opp. at 60-61 (HHS's "decision to reinstate the physical separation requirements was not based on grantees' failure to observe existing regulatory limits"); *see also id.* at 44, 49). Even when an agency acts prophylactically, however, there must be some likelihood that the issue that the agency addresses will actually occur. *See Stilwell v. Office of Thrift Supervision*, 569 F.3d 514, 519 (D.C. Cir. 2009).[15] Here, HHS willfully disregards evidence, from its own auditors as well as grantees and providers, that Title X funds are not vulnerable to abuse and that future problems in funding segregation are unlikely to arise.[16]

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[14] *See* Gallagher Decl. (VT) ¶ 6; Gillespie Decl. (WI) ¶28; Handler Decl. (NV) ¶ 11; Nelson Decl. (MD) ¶10; Alifante Decl. (NJ) ¶ 28.

[15] *Marina Mercy Hosp. v. Harris*, 633 F.2d 1301, 1304 (9th Cir. 1980), which addressed agency action in a program "ripe with potential for abuse," is thus inapposite.

[16] *See supra* n. 3 Napili 2017 Family Planning Report at 22; Napili 2018 Family Planning Report at 14. Both reports explain that HHS's monitoring includes "(1) careful review of grant

The factors that HHS identifies to support the separation requirement, including claims of a general sense of confusion—in reality, caused by the proposed rule itself rather than the current rules—and irrelevant instances of Medicaid (not Title X) billing, consist of assumptions and conclusions that lack record support. (*See* Opp. at 60-61). The separation requirement, which departs from HHS's policy over the last 30 years, takes aim at provider misconduct, that in reality, does not exist. *Nat'l Fuel*, 468 F.3d at 834 (setting aside agency's revisions to its standard of compliance where administrative record "did not contain a single example of abuse").[17]

HHS also attempts to sweep aside the substantial reliance interests that Plaintiffs have identified by arguing that these interests are not legally cognizable. Based on a misreading of *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117 (2016), HHS contends that it was not obligated to take these interests into account because they are not "substantive statutory rights" and instead concern "discretionary funding decisions." (Opp. at 49-50). In *Encino*, an auto dealership challenged a Department of Labor rule that reclassified certain employees, who were formerly exempt from the Fair Labor Standards Act ("FLSA"), as non-exempt. 136 S. Ct. 2117 (2016). The Supreme Court vacated the rule in part because the agency failed to take into account the employer's reliance interests on the former policy. The *Encino* Court's decision did not depend on the dealership's "substantive rights" under the FLSA, but rather on the

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applications . . . (2) independent financial audits. . . (3) yearly comprehensive reviews of the grantees financial status and budget report; and (4) periodic and comprehensive program reviews and site visits by OPA regional offices." *Id.*

[17] HHS attempts to distinguish *Nat'l Fuel* on the basis that it did not impose an obligation on all agencies to support their policies with empirical evidence. (Opp. at 47). The States, however, cited *Nat'l Fuel* for the narrower proposition that when an agency changes standards of regulation to address purported industry misconduct, it must provide some evidence to show that it is a "real problem." (States' Mem. at 33).

determination that employer had organized its business around the expectation that certain employees would be exempt. *See id.* at 2126 ("Dealerships and [employees] negotiated and structured their compensation plans against this background understanding. Requiring dealerships to adapt to the Department's new position could necessitate systemic, significant changes to the dealerships' compensation arrangements.").

Here too, Title X providers have long organized their business models around the expectation of financial, but not physical, separation. The Final Rule necessitates systemic and significant changes to providers' organizational structures and, as a result, will ultimately cause disruption of service to Title X's clients. *See also* *Nat'l Lifeline Ass'n v. Fed. Commc'ns Comm'n*, No. 18-1026, 2019 WL 1549886, at *8 (D.C. Cir. Feb. 1, 2019) (agency failed to consider that plaintiffs had, in service of low income customers, "developed a business model based" on the prior policy).[18] Moreover, the interests of low-income patient beneficiaries, whom Title X is explicitly designed to serve, are statutorily based. *See* 42 U.S.C. § 300a-4(c).[19]

HHS also disregards the magnitude of the costs that the separation requirements will impose on providers and patients. First, HHS estimates with no basis that compliance costs range between $20,000 and $40,000 per site, and misconstrues Plaintiffs' argument as "insist[ing] that the costs of compliance will be significantly higher for some providers." (Opp. at 59). The States do not merely contend that providers in *some* instances could possibly have to

[18] *Janus v. Am. Fed'n of State, Cty., & Mun. Employees, Council 31*, 138 S. Ct. 2448, 2484 (2018), which does not even address reliance interests in the APA context, is irrelevant. Other courts have found that, under the APA, discretionary funding decisions can produce cognizable reliance interests. *See* *Nat'l Lifeline Ass'n*, 2019 WL 1549886, at *8 (wireless carrier subsidies); *Am. Bar Ass'n v. United States Dep't of Educ.*, No. 16 Civ. 2476 (TJK), 2019 WL 858770, at *7 (D.D.C. Feb. 22, 2019) (student loan forgiveness).

[19] Even when the privileges of a government program's beneficiaries are not codified by statute, however, they may nevertheless be sufficient to engender reliance interests. *See* *NAACP v. Trump*, 298 F. Supp. 3d 209, 238 (D.D.C. 2018).

pay more than $40,000, but that providers on average will have to pay hundreds of thousands of dollars more based on credible estimates. (*See* States' Mem at 38).

Contrary to the evidence before it, HHS further argues that the prospect of exodus is "speculative." (Opp. at 58). Planned Parenthood – which currently provides 40 percent of the program's contraceptive care overall, and between 70 to 100 percent in the Plaintiff States of Vermont, New Jersey, Minnesota, and Connecticut – has already made clear that it will withdraw from the program if the rule becomes effective.[20] Other Title X providers could experience an average caseload increase of 70 percent.[21] Nevertheless, HHS claims that it does not anticipate a decrease in the number of providers because other entities will apply. (Opp. at 57). Not only does the Department's blithe conclusion fail to consider the disruption of service between the withdrawal of current providers and the installation of new ones, but it also does not examine whether and to what extent new providers will be able to support the previous caseload.

In short, HHS's contention that the 2000 regulations have engendered no reliance interests must be rejected. The record amply demonstrates otherwise.

c. Changes to the quality and scope of the program are arbitrary and capricious.

The changes that the Final Rule makes to interpretations of "acceptable and effective family planning methods" usher in a policy change away from evidence-based care. HHS has long required "acceptable and effective" care under the Title X statute to be "medically approved." (*See* States' Mem. at 26, 38-39). HHS's claim that, in recent years, the "medically approved" standard had "prove[n] unworkable" is unsubstantiated. (Opp. at 54). Grantees, providers, and HHS itself have been able to comply with and apply the standard for the last 20

[20] PPFA Ltr. 15; Guttmacher Ltr. Table 1.
[21] *See* Guttmacher Ltr. 9-10.

years.[22] In fact, the "medically approved" requirement addresses the exact problem that HHS identifies about potential ambiguity as to who decides what constitutes a sufficiently acceptable and effective family planning method. *See* 84 Fed. Reg. at 7732. Without it, providers will be left with no standards or guidance to interpret the statutory requirement and any risk of confusion would presumably intensify.[23] As the Guttamacher Institute explained, this concern is particularly troubling in the context of antiabortion organizations that do not employ medical staff or stock the most common forms of FDA-approved care.[24]

Defendants also downplay the effect of the Final Rule's new "family planning" definition. (Opp. at 55). Together with the elimination of the "medically approved" requirement, however, these changes confirm HHS's deliberate shift from prior understandings of a "broad range" of effective care. HHS has for years interpreted a "broad range" of methods to include a broad range of contraceptive methods[25] and its clinical guidelines specify that, when patients have adequate access to a range, they will "be more likely to select a method that they will use consistently and correctly."[26] HHS also is aware that contraception is significantly more effective than other methods of avoiding unintended pregnancy,[27] which is why it is unsurprising that only 0.5 percent of Title X patients presently use natural family planning methods.[28]

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[22] QFP at 7; WA Ltr. 14; NY Ltr. 9; NY DOH Ltr. 6; CA Ltr. 17-18; ACOG Ltr. 10-11; AAN Ltr. 5; PPFA Ltr. 65-66; Guttmacher Ltr. 1-2.

[23] Even if there was confusion, at the margins, about what constituted a medically approved form of family planning, HHS may not use that as an excuse for a dramatic policy shift on contraceptive care. *See* *State Farm*, 463 U.S. at 43 (an agency must articulate a "rational connection between the facts found and the choice made").

[24] *See* Guttmacher Ltr. 15.

[25] QFP at 2, 8, 11, 37, 39, 40; Napili 2017 Family Planning Report at 15 (having broad range of contraceptive options was one of Title X key priorities for 2017).

[26] QFP at 37.

[27] 84 Fed. Reg. 7728-29; QFP at 47.

[28] Guttmacher Ltr. 4.

By contrast, the Final Rule no longer construes "broad range" to refer to a range of contraceptive methods, and instead defines contraception itself as one option among a broad range of other family planning methods. (Opp. at 54). The Rule thus allows Title X projects to offer primarily guidance on non-medically approved natural family planning methods and abstinence, as long as a few sites still offer limited forms of contraception. Nevertheless, HHS does not explain the reasons for the change. *See id.* 53-54.

HHS's assertion that it is merely reverting back to Title X's statutory text ignores that it is actually abandoning its prior interpretation of that text. (Opp. at 54-55). The changes to the definitions of "acceptable and effective" as well as "broad range of family planning" methods eliminate the protections currently in place for a broad range of FDA-approved contraceptive care. Given the effectiveness of non-contraceptive options, these changes will, in fact, deter HHS from achieving its purported goal of deceasing current rates of unplanned pregnancies. *See* 84 Fed. Reg. 7730 (if Title X sites "provide a broad range of family planning methods and services to prevent pregnancy, the results will likely include, among other things, a decrease in pregnancy and with it, a decrease in the incidence of abortion").

4. HHS failed to satisfy the APA's procedural requirements.

Restrictions on non-APP staff: HHS concedes that the restrictions on non-APP staff from providing pregnancy options counseling included in the Final Rule appear nowhere in the Proposed Rule, Opp. at 52, 61-62, and are left to argue only that the Final Rule is a "logical outgrowth" of the proposal. But the public did not receive notice from the Proposed Rule of these restraints.[29]

[29] *Hodge v. Dalton*, 107 F.3d 705 (9th Cir. 1997) and *Envtl. Def. Ctr., Inc. v. E.P.A.*, 344 F.3d 851 (9th Cir. 2003) ("EDC") are distinguishable because in both cases the complaining party

As discussed supra II.A.3.a, the Proposed Rule permitted only doctors to provide patients with so-called referral lists, but did not provide any explanation for the limitation, and consequently, did not put the public on notice of the agency's underlying rationale for the proposal. The rest of the Proposed Rule focused almost exclusively on HHS's intent to regulate abortion-related care, specifically to ensure that "none of the funds appropriated for Title X may be used in programs where abortion is a method of family planning and related statutory requirements." 83 Fed. Reg. at 25502; *see generally* 83 Fed. Reg. at 25502-33. Like the prohibition on abortion referrals, the referral list restrictions, the prenatal care directive, and the separation requirements, the provision barring non-doctors from providing the referral list appeared to arise from HHS's purported concerns about abortion. Nothing in the Proposed Rule allowed the public to anticipate that HHS would restrict non-APPs from "nondirective" *pregnancy counseling*. The public did not have the opportunity to submit comments and evidence to the agency about the importance of non-APPs to the organizational structure of Title X providers, the high quality of their services, and the damage the new pregnancy counseling restrictions would inflict on patient care.

HHS's attempt to frame the limited language in the Proposed Rule about specific forms of abortion counseling broadly as addressing the question of "which types of providers and/or staff may engage with and provide information to patients" (Opp. at 61) is an unpersuasive post hoc justification. Following HHS's logic, the few sentences that it cites from the Proposed Rule were sufficient notice for prohibiting any staff member from engaging with or providing

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received sufficient notice of changes in a final rule based on the agency's original reasons for and analysis of the rule. *See* *Hodge*, 107 F.3d at 711-12 (explaining that plaintiff had adequate notice of change from rationale in original proposal and noting the Final Rule's detailed legal analysis of basis for changes); *EDC*, 344 F.3d at 852 (upholding agency action where final rule contained "no elements that were not part of the original [proposed] rule").

information to patients. In other words, HHS would be free, without additional notice and comment, to exclude all non-APP staff, or even all non-doctors, from any patient interaction. This is an implausible interpretation of the APA's procedural requirements, which require a final rule's provisions to be properly foreshadowed in proposals and comments. *See* *Nat. Res. Def. Council* v. EPA, 279 F.3d 1180,1188 (9th Cir. 2002).

Regulatory impact statement: HHS's regulatory impact analysis also failed to meet the APA's procedural requirements. Not only did HHS fail to consider at all the costs resulting from the harms to the public health, but even with regard to the costs of the separation requirement, the cost projections that HHS made relied on material from undisclosed sources, which prevented the public from meaningfully commenting on the agency's methodology. HHS does not deny that the record lacks support for both HHS's estimate that compliance with separation requirements would cost between $20,000 and $40,000 and the determination that there would be no health-care costs resulting from the loss of current providers. *See* Opp. at 62-63; States' Mem. at 42-43. These failures deprived "affected parties an opportunity to present comment and evidence to support their positions, and thereby to enhance the quality of judicial review." *Chamber of Commerce v. SEC*, 443 F.3d 890, 900 (D.C. Cir. 2006).

HHS objects that Executive Orders 12,866 and 13,563 – which require that federal agencies quantify the costs and benefits of their proposed regulations wherever possible – are not privately enforceable, *see* Opp. at 51-52, but the States nowhere rely on these Executive Orders in support of the motion for preliminary injunction. (*See* States' Mem. at 34-35). HHS's failure to disclose any analysis of the ostensible costs and benefits of the proposed rulemaking violates the APA's notice requirement standing alone, *see* 5 U.S.C. §§ 553(b), (c), 706(2)(D), and it is

solely on APA grounds that the States seek to set aside this rulemaking for procedural defeciencies, independent of any noncompliance with applicable Executive Orders.

B. The facts are undisputed that the States will suffer irreparable harm absent preliminary injunctive relief.

In their opening papers, the States proved numerous categories of harm to their interests, including their interests in preserving the public health by preventing unintended pregnancies,[30] undetected cancers and undetected STIs.[31] In response, HHS merely cites authority relating to *parens patriae* claims, which the States did not assert. Rather, the injuries shown in the States' declarations are to the interests of the States themselves. *See* *Planned Parenthood of Greater Washington & N. Idaho v. U.S. Dep't of Health & Human Servs.*, 328 F. Supp. 3d 1133, 1150-51 (E.D. Wash. 2018) (reduction in services and funding to state's pregnancy prevention program is irreparable injury); *accord* *Doe v. Trump*, 288 F. Supp. 3d 1045, 1082 (W.D. Wash. 2017).

HHS also argues that the States are claiming an injury from a rule that regulates "someone else," which it argues is merely an "attenuated chain of events" leading to "speculative harms." **(**Opp. at 66). However, HHS neither cites, nor counters, nor attempts to distinguish the dozens of declarations filed by the States that show harms to the States themselves in the form of, for example, increased health care costs and the loss of direct Title X grant funding to many of the States through their health departments. Thus, on the record before the Court, the States' showing of irreparable injury is undisputed. Nor does HHS make any attempt to distinguish the Ninth Circuit's recent ruling in *California v. Azar*, 911 F.3d 558, 581 (9th Cir. 2018), which is

[30] For example, as shown in the Supplemental Declaration of Bruce S. Anderson. ¶¶ 4, 8-9. in Hawaii, this means that there is already a shortfall of family planning providers and funding, even before the Final Rule would take effect -- due in part to the recent actions of HHS.

[31] *See, e.g.*, States' Mem. at 45-46, nn. 50-57 and the declarations cited therein; *see also* Supplemental Declaration of Melissa Weiler ("Weiler Decl") ¶¶ 12-15.

directly on point. In *California*, the Ninth Circuit evaluated state standing and irreparable injury from interim final rules that would have decreased the availability of birth control coverage under self-insured health plans, resulting in additional state health care expenses.[32] As here, the state plaintiffs had both substantive and procedural APA challenges—the procedural challenges resulting from their lack of opportunity to comment the terms of the rules. As here, in *California*, the federal government argued that any injury to the state was too attenuated because the rule regulated someone else, in that case, self-insured employers, and so the chain of causation was too attenuated. *Id.* at 571-72. The Ninth Circuit rejected this argument:

> The states show, with reasonable probability, that the IFRs will first lead to women losing employer-sponsored contraceptive coverage, which will then result in economic harm to the states. *See Citizens for Better Forestry*, 341 F.3d at 969. Just because a causal chain links the states to the harm does not foreclose standing. *See Maya v. Centex Corp.*, 658 F.3d 1060, 1070 (9th Cir. 2011) ("A causal chain does not fail simply because it has several 'links,' provided those links are not hypothetical or tenuous" (internal quotation marks and citation omitted)). The states need not have already suffered economic harm. *See City of Sausalito v. O'Neill*, 386 F.3d 1186, 1197 (9th Cir. 2004) (requiring only that the protected concrete interest be "threatened"). There is also no requirement that the economic harm be of a certain magnitude. *See United States v. Students Challenging Regulatory Agency Procedures (SCRAP)*, 412 U.S. 669, 689 n.14, 93 S.Ct. 2405, 37 L.Ed.2d 254 (1973) (explaining that injuries of only a few dollars can establish standing).

Similarly, the Ninth Circuit upheld the district court's finding of irreparable injury: "The district court additionally found that the states face 'potentially dire public health and fiscal consequences as a result of a process as to which they had no input' and highlighted the public

[32] Although this loss is in part a financial one to the States here (as it was to the states in *California*), HHS apparently is forced to concede that *California* is directly on point in holding that financial loss caused by an unlawful federal rule constitutes irreparable injury "because the states will not be able to recover monetary damages." 911 F.3d at 581.

interest in access to contraceptive care. This finding is sufficiently supported by the record." *Id.* at 581-82. The undisputed declarations in the record here show that the same facts are present.[33]

As to the Hobson's choice shown by the grantee states, the choice of either accepting Title X funds under unlawful conditions or forfeiting these funds and suffering the economic and public health consequences,[34] HHS merely denies the existence of any such dilemma because it maintains that the Final Rules are lawful. (Opp. at 66). Thus, if the Court agrees with the States that they have made a strong showing of the likelihood of success on the merits, their irreparable injury from having to face this dilemma is also undisputed. *See* *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 381 (1992) (a forced choice between complying with a law plaintiff contends is unconstitutional and penalties for violating that law was sufficient to establish irreparable injury).

C. The balance of equities and public interest sharply favor preliminary relief.

All parties are in agreement that when the government is a party, courts consider the balance of equities and the public interest together. *Drakes Bay Oyster Co. v. Jewell*, 747 F.3d 1073, 1092 (9th Cir. 2014). As the Ninth Circuit noted in *California*, "[t]he public interest is served by compliance with the APA." 911 F.3d at 581. In contrast, "[t]here is generally no public interest in the perpetuation of unlawful agency action." *League of Women Voters of U.S. v. Newby*, 838 F.3d 1, 12 (D.C. Cir. 2016). In response, HHS argues it "will 'suffer[] a form of irreparable injury' if it 'is enjoined by a court from effectuating statutes enacted by representatives of its people.'" (Opp. at 59 (quoting *Maryland v. King*, 567 U.S. 1301, 133 S. Ct. 1, 3 (2012) (Roberts, C.J., in chambers) (citation omitted)(involving a stay of judgment in a criminal case)).

[33] *See, e.g.*, States' Mem. at 45-47, nn. 50-57 and the declarations cited therein; Weiler Decl. ¶¶ 11-18.
[34] *See, e.g.*, States' Mem. at 48, n. 62 and the declarations cited therein.

Of course, in this case, the States seek to enjoin not implementation of a statute, but an administrative rule enacted by HHS *contrary to three statutes*: the Nondirective Mandate, the ACA and the terms of Title X itself. Indeed, in this instance as in many others, the current administration was forced to use an administrative rule to try to effectuate its policies specifically because it could *not* convince the representatives of the people to enact the legislation it sought.[35] The balance of equities supports injunctive relief.[36]

D. Scope of provisional relief

1. The Court should issue a nationwide injunction or stay the effective date of the rule.

As set forth in the States' opening brief, the standard remedy for violations of the APA is to vacate the agency action. (States' Mem. at 50-51; *see also Nat'l Mining Ass'n v. U.S. Army Corps of Eng'rs*, 145 F.3d 1399, 1409 (D.C. Cir. 1988)). Indeed, the Ninth Circuit has recognized that a "nationwide injunction . . . is compelled by the text of the [APA], which provides [that] [t]he reviewing court shall . . . hold unlawful and set aside agency action" that violates any provision of 5 U.S.C. § 706. *Earth Island Inst. v. Ruthenbeck*, 490 F.3d 687, 699 (9th Cir. 2007), *aff'd in part, rev'd in part on other grounds sub nom. Summers v. Earth Island Inst.*, 555 U.S. 488 (2009). HHS's attempt to circumvent the clear requirement that unlawful agency action be "set aside" is unavailing.

Also noted in the States' opening brief, at 50, the "scope of injunctive relief is dictated by the extent of the violation established, not by the geographical extent of the plaintiff class."

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[35] *See, e.g.*, Erica Werner, "Senate easily defeats measure to defund Planned Parenthood," WASHINGTON POST (Aug. 23, 2018).

[36] Additionally, on this issue as on most others, HHS resorts to an argument that "*Rust* blessed highly similar regulations." (Opp. at 70). HHS fails to identify the public interest that follows from this observation or explain how any such interest would supersede its obligation to comply with the APA 31 years later.

Califano v. Yamasaki, 442 U.S. 682, 702 (1979). HHS has not refuted the States' position that the violation here is nationwide and requires a nationwide remedy.[37]

HHS has also failed to explain how the nationwide scope of the provisional relief would harm it. *See Califano*, 442 U.S. at 702 (noting that a nationwide scope "does not necessarily mean that the relief afforded the plaintiffs will be more burdensome than necessary to redress the complaining parties"). The purported "harms" HHS cites are that (a) other courts are considering these issues in separate litigation and (b) some States are in favor of the Final Rule. (Opp. at 75). Neither of these is a harm to HHS. Nor does HHS provide a justification for limiting the geographic scope of the injunction.

First, HHS's concern that the provisional relief provided in this case would be harmful because other districts are considering similar challenges is unfounded. Granting the provisional relief here would not prevent other courts from continuing to litigate the merits of these issues; it would simply preserve the status quo until the issues can be finally decided. *See Califano*, 442 U.S. at 702-03 (rejecting argument that nationwide class inappropriately prevented adjudication by other courts).[38]

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[37] The cases that HHS cites in support of itsposition – most of which do not involve an APA challenge to agency rulemaking – are factually distinct and do not control here. *Gill v. Whitford*, 138 S. Ct. 1916, 1933-34 (2018) (finding plaintiffs lacked standing where they failed to demonstrate they were harmed by alleged gerrymandering); *California*, 911 F.3d at 584 (insufficient record of economic impact on 45 non-plaintiff states); *Los Angeles Haven Hospice, Inc. v. Sebelius*, 638 F.3d 644, 665 (9th Cir. 2011) (nationwide injunction would "significantly disrupt" the administration of Medicare and result in "great uncertainty and confusion"); *Madsen v. Women's Health Ctr.*, 512 U.S. 753, 767-68 (1994) (considering appropriateness of injunctive relief, not geographical applicability); *Zepeda v. U.S. Immigration & Naturalization Serv.*, 753 F.2d 719, 723, 728-29 (9th Cir. 1983) (nationwide injunction against enforcement activities inappropriate where plaintiff class not certified).

[38] Indeed, in numerous recent instances, entry of nationwide injunctive relief by one district judge did nothing to interfere with adjudication of similar or identical challenges to federal agency action by other federal judges in other districts. *See, e.g.*, *Kravitz v. U.S. Dep't of*

Second, the fact that some states are in favor of the Final Rule is not a reason to deny Plaintiffs the remedy that was envisioned by the APA. Amici States of Ohio et al. argue that, for example, Oregon is seeking to impose its "values" on Ohio. (*Amici Curiae* Br. filed by the States of Ohio et al. (filed Apr. 11, 2019), Doc. 89-1 at 18). Amici seem to believe that this case is about whether an individual state supports or opposes abortion. However, this case is not a plebiscite on abortion, but rather will determine whether the Final Rule is legally impermissible. Oregon, Ohio, and every state in the nation share an interest in ensuring that established federal law is followed.

HHS notes that district courts enjoining the 1988 regulations limited the relief to the parties before them. (Opp. at 73). However, there is nothing in those cases to indicate that the plaintiffs sought broader relief, and there is certainly no analysis by those courts concluding that nationwide relief was inappropriate. *See* *W. Va. Ass'n of Cmty. Health Centers, Inc. v. Sullivan*, 737 F. Supp. 929, 956-57 (S.D. W. Va. 1990); *Planned Parenthood Fed'n of Am. v. Bowen*, 687 F. Supp. 540, 544 (D. Colo. 1988); *Massachusetts v. Bowen*, 679 F. Supp. 137, 148 (D. Mass. 1988). Indeed, the District of Massachusetts court indicated that a nationwide solution seemed apt in those circumstances. 679 F. Supp. at 148 ("I assume that the Secretary [of Health and Human Services], as a responsible public official, will apply this judicial determination evenhandedly to all similarly situated entities in the United States.").

Commerce, No. 8:18-cv-01041-GJH, at 117-18 (D. Md. Apr. 5, 2019) (vacating agency decision to add citizenship question to U.S. Census and issuing nationwide permanent injunction); *California v. Ross*, 358 F. Supp. 3d 965, 1049-51 (N.D. Cal. 2019) (same); *New York v. U.S. Dep't of Commerce*, 351 F. Supp. 3d 502, 673-78 (S.D.N.Y. 2019) (same); *NAACP v. Trump*, 315 F. Supp. 3d 457, 460-62 (D.D.C. 2018) (in denying reconsideration of vacatur of agency decision to rescind the Deferred Action for Childhood Arrivals program, noting that the same rescission had been preliminarily enjoined in district courts in California and New York).

A nationwide injunction would advance the public interest by preserving decades-long practices under the Title X statute, preventing serious and lasting harm upon the States, and ensuring uniformity in the administration of federal law pending resolution of the merits. HHS's inapposite arguments have failed to refute the States' points in *this* case that (a) HHS finds it necessary that the Title X program be administered uniformly; (b) the impact of the Final Rule is nationwide, requiring a nationwide solution; and (c) the private plaintiffs in *Am. Med. Ass'n v. Azar*, No. 6:19-cv-00318-MC (filed Mar. 5, 2019) include constituents that are impacted by the Final Rule in all 50 states. (States' Mem. at 51).

Finally, HHS failed to address the law cited by the States in their opening brief showing that a nationwide stay of the Final Rule is appropriate under Section 5 of the APA, 5 U.S.C. § 705. (States' Mem at 51-52). Indeed, HHS mentions the availability of a stay under § 705 only in a footnote. (Opp. at 76 n.10). And that footnote does not provide any reason why § 705 should not apply in the present circumstances.

2. Implementation of the entirety of the Final Rule should be enjoined or postponed.

The Court should reject HHS's unsupported, conclusory suggestion that the Court enjoin some, but not all, of the Final Rule. (Opp. at 65). *Texas v United States Envtl. Prot. Agency*, 829 F.3d 405, 435 (5th Cir. 2016), cited in the States' opening brief, is directly on point in staying an agency final rule "in its entirety" when the government offered only a "cursory" argument to the contrary. There, the court noted that "neither party has briefed how we might craft a limited stay." 829 F.3d at 435. Here, HHS has offered the most cursory of arguments, and similarly failed to suggest guidance on how the court might invalidate some provisions of the Final Rule but not others. In arguing that "[t]he separation requirements can function without the referral provisions and vice versa" (Opp. at 76), for example, HHS fails to address how the separation

requirements, which incorporate the gag requirement by reference, can be effectuated independently while still operating to accomplish HHS's proposed regulatory scheme. Nor does HHS attempt to argue that the problematic definitions of "advanced practice provider" and "family planning" can be removed without changing the meaning of the other provisions of the Final Rule that repeatedly use those terms.

As the court held in *MD/DC/DE Broadcasters Ass'n v. FCC*, 236 F.3d 13 (D.C. Cir. 2000), "[w]hether the offending provision of a regulation is severable depends upon the intent of the agency *and* upon whether the remainder of the regulation could function sensibly without the stricken provision." 236 F.3d at 22 (citation omitted) (emphasis in original). HHS has not advanced any support for its broad assertion that the Final Rule can, or should, function if only certain of its provisions are enjoined.

Should the Court be inclined to credit HHS's position on severability, it should still preliminarily enjoin implementation of the entirety of the Final Rule. If only a portion of a final rule is deemed invalid, and such portion is deemed severable, the appropriate action is a remand to the agency (while the entire rule is enjoined) in order to allow the agency to consider in the first instance how to proceed. *See New York v. U.S. Dep't of Labor*, No. 18-1747, 2019 WL 1410370, at *21 (D.D.C. Mar. 28, 2019) (vacating final rule and remanding to agency).

Finally, again, HHS's severability argument ignores the Court's clear authority under 5 U.S.C. § 705 to postpone the effective date of agency action "to the extent necessary to prevent irreparable injury." As discussed above in Part II.B., such postponement is necessary here.

III. Conclusion

The States' motion should be granted and the Final Rule should be enjoined pending a final ruling on the merits. However, if the Court were to deny the States' motion for a

preliminary injunction, the States intend to immediately appeal to the Ninth Circuit. The States respectfully request that the Court, if it were to deny the motion for preliminary injunction, grant a temporary injunction, staying the final rule while an appeal is pending. Alternatively, the States would request the Court at least grant a temporary injunction staying the rule while the States file with the Ninth Circuit, and that Court decides, an emergency motion for an injunction pending appeal. *See* Ninth Circuit Rule 27-2 and 27-3. The States intend this request to satisfy Federal Rule of Appellate Procedure 8(a)(1).

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Respectfully submitted,

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