IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

MAYOR AND CITY COUNCIL OF BALTIMORE, *Plaintiff*, v. ALEX M. AZAR II, in his official capacity as the Secretary of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; DIANE FOLEY, M.D., in her official capacity as the Deputy Assistant Secretary, Office of Population Affairs; OFFICE OF POPULATION AFFAIRS, *Defendants*.	Case No. 1:19-cv-01103

PLAINTIFF'S MEMORANDUM IN SUPPORT OF
MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

The Mayor and City Council of Baltimore ("Baltimore City") is entitled to summary judgment that HHS's Rule, entitled *Compliance With Statutory Program Integrity Requirements*, 84 Fed. Reg. 7,714 (Mar. 4, 2019) ("the Rule") is unlawful for the following reasons.

First, the Rule violates the "Nondirective Mandate," the rider included in every annual Title X appropriation since 1996, requiring that "all pregnancy counseling shall be nondirective." Continuing Appropriations Act, 2019, Pub. L. 115–245, 132 Stat. 2981, 3070–71 (2018) ("Non-directive Mandate"); *see also* 65 Fed. Reg. 41,272-73.

Second, the Rule violates the "Non-Interference Mandate," a provision of the Affordable Care Act (ACA) that bars HHS from "promulgat[ing] any regulation" that interferes with full disclosure of treatment information between doctors and patients or otherwise unreasonably interferes with patient access to timely health care. 42 U.S.C. § 18114 (enacted as ACA § 1554) ("Non-Interference Mandate").

Third, the Rule violates Title X's "Non-Coercion Mandate," which provides that "[t]he acceptance by any individual of family planning services ... provided through [Title X] ... shall be voluntary," 42 U.S.C. § 300a-5. HHS *itself* interprets this to require grantees to "[p]rovide services without subjecting individuals to any coercion ... to employ or not to employ any particular methods of family planning." 45 Fed. Reg. 37,433, 37,437 (June 3, 1980); *accord* 84 Fed. Reg. at 7731-7732, 7735, 7745.

Fourth, the Rule violates the Administrative Procedure Act (APA) because it is arbitrary and capricious. *See* 5 U.S.C. § 706(2)(A). The Rule is arbitrary and capricious because: (1) HHS failed to explain or even acknowledge its change in position on the best interpretation of the Nondirective Mandate; (2) HHS's explanation that it "disagrees" that the Rule infringes on the legal, ethical, and professional obligations of medical professionals is inadequately explained

and contrary to the evidence before the agency; (3) HHS inadequately considered the reliance interests that its abrupt policy reversal would disrupt, and its explanation for disregarding those interests was contrary to the evidence before it; (4) HHS inadequately considered the likely costs and benefits of the physical and financial separation requirement; and (5) HHS adopted unexplained and irrational limitations on who may engage in pregnancy counseling.

Fifth, the Rule violates the APA because HHS promulgated it without observance of procedure required by law. 5 U.S.C. § 706(2)(D). HHS: (1) unreasonably declined to hold open the comment period long enough to provide commenters a meaningful opportunity to comment on the Proposed Rule, to their material prejudice; and (2) fundamentally altered a key component of the Rule—*who* may engage in nondirective counseling—without offering interested parties any opportunity to comment on the decision at all.

Sixth, the Rule violates the First Amendment because it: (1) unconstitutionally restricts private speech on the basis of viewpoint; (2) unconstitutionally interferes with the doctor-patient relationship; (3) selectively withholds information from patients on the basis of viewpoint; and (4) violates patients' rights to receive truthful and unbiased information from their doctors.

Seventh, the Rule violates the Fifth Amendment's equal protection guarantee because it constitutes "gender-based government action,"—as both (1) a sex-based classification and (2) a Rule that promotes sex stereotypes—and Defendants cannot provide an "exceedingly persuasive justification." *United States v. Virginia*, 518 U.S. 515, 531 (1996).

STATEMENT OF UNDISPUTED FACTS

I. The Title X Program

1. Title X is the only federal program specifically dedicated to funding family planning services. *See* Public Health Service Act ("PHSA"), 84 Stat. 1506, as amended 42 U.S.C. §§ 300 to 300a-6. Title X provides lump-sum grants that may be used both to cover the costs of family

planning care for the un- or under-insured and to pay for non-service costs like purchasing contraceptives or training staff. *Id.* § 300; *see also* Opinion on Prelim. Inj. at 4, ECF 43 ("PI Op."). Title X funds may not be used to pay for abortion services. 42 U.S.C. § 300a-6.

2. Title X programs provide quality sexual and reproductive healthcare, including contraceptive supplies and information, to all who need them on a voluntary and confidential basis, with priority given to individuals with low income. Kost Decl., PEP112 ¶ 30.[1] In addition to offering a broad range of effective contraception, Title X-funded clinics provide contraceptive education and counseling; breast and cervical cancer screening; testing, referral, and prevention education for sexually transmitted infections/diseases ("STIs/STDs"), including human immunodeficiency virus ("HIV"); and pregnancy diagnosis and counseling. Kost. Decl., PEP109 ¶ 15, PEP118-120 ¶¶ 52-58. Women prefer Title X-funded clinics over other healthcare outlets. Bailey Decl., PEP67-68 ¶¶ 47-50. These sites offer more effective types of contraception and better contraceptive counseling, provide a greater variety of services on site, and have better appointment availability. *Id.*, PEP63-66 ¶¶ 36-45.

A. Baltimore City's Title X Program

3. Baltimore City has participated in the Title X program since its inception. Before the Rule took effect, the Baltimore City Health Department received $1,430,000 annually in funding subject to Title X rules through subgrants from the Maryland Department of Health. It directly operates three community clinics and four school-based health centers that provided Title X services, and it provided funding to ten additional subgrantees in Baltimore.[2]

[1] For ease of reference, Plaintiff's Exhibits are continuously numbered and referenced here as "Plaintiff's Exhibit Pages" or "PEPs."

[2] "Baltimore City" refers to the Plaintiff, Mayor and City Council of Baltimore. "Baltimore" refers to the city as an entity.

4. The Title X program served as the final safety net for healthcare for one third of women living in Baltimore. In 2017, 16,000 patients in Baltimore received care through Title X clinics, including 7,670 patients at clinics with funding overseen by Baltimore City. Of these patients, 86 percent had incomes at or below the federal poverty line, and 99.8 percent had incomes at or below 250 percent of the line. Hager Decl., PEP381 ¶ 7.

5. The services provided by Baltimore's existing network of qualified Title X providers have had a significant positive impact on family health and well-being and on public health generally. Title X-provided contraception has decreased unintended pregnancy and abortion rates across the United States. Kost Decl., PEP114 ¶ 35. Baltimore City in particular has used Title X funding in its public health efforts, including a 55% reduction in teen pregnancy over the last ten years. Hager Decl., PEP383 ¶ 11. Baltimore City has relied on the Title X funding to reduce unintended pregnancy, treat and reduce the spread of sexually transmitted infections, screen for breast and cervical cancer, and ensure healthcare access for its most vulnerable residents. Mobley Decl., PEP366, ¶ 17. Title X providers in Baltimore have worked especially hard to earn the trust of patients who often distrust and fear medical institutions. *Id.* PEP371 ¶ 43.

6. Until recently, Planned Parenthood operated additional Title X sites within Baltimore. In August 2019, as a result of the Rule, Planned Parenthood, which serves forty percent of Title X patients, withdrew.[3] Moreover, all the State-funded Planned Parenthood clinics in at least eight states, including Maryland, will no longer operate using Title X money.[4] Clinics have already

[3] *See* Pam Belluck, *Planned Parenthood Refuses Federal Funds Over Abortion Restrictions*, N.Y. Times (Aug. 19, 2019), https://nyti.ms/34nIqM8.

[4] *See* Carter Sherman, *6 States Are Now Rejecting Federal Money Because of Trump's Abortion 'Gag Rule,'* Vice News (Aug. 30, 2019), https://bit.ly/2kpNSfZ (explaining that all of the clinics in six states have already rejected money and the clinics in Maryland and Massachusetts will follow).

begun to close, including two in Ohio that served more than 6,000 patients a year.[5]

II. HHS's New Rule

7. On May 22, 2018, HHS released a notice of proposed rulemaking entitled *Compliance With Statutory Program Integrity Requirements*, 83 Fed. Reg. 25,502 (June 1, 2018) ("Proposed Rule"). *See* PI Op. at 9.

8. Among other things, the Proposed Rule included provisions that severely limited, and in many circumstances barred, Title X recipients from providing their patients with referral and counseling for abortion services, and mandated referrals for prenatal care for women who became pregnant. The Proposed Rule also included provisions requiring strict physical separation between Title X services and any healthcare services that did not comply with the new restrictions on abortion referrals, counseling, and services. The Proposed Rule also barred anyone at a Title X project but physicians from engaging in Nondirective Counseling.

9. The nation's leading non-partisan medical associations, counting more than 90 percent of the nation's OB-GYNs among their members, submitted comments opposing the changes contemplated by the Proposed Rule. The groups included the American Medical Association ("AMA"), PEP443-448, the American College of Obstetricians and Gynecologists ("ACOG"), PEP583-601, the American College of Physicians ("ACP"), PEP661-670, the American Academy of Family Physicians ("AAFP"), PEP456-460, the American Academy of Nursing ("AAN"), PEP464-470, and the American Academy of Pediatrics ("AAP"), PEP602-613.

10. On March 4, 2019, HHS published the final Rule entitled *Compliance With Statutory Program Integrity Requirements*, 84 Fed. Reg. 7714 (Mar. 4, 2019) (to be codified at 42 C.F.R.

[5] *See* Nicquel Terry Ellis, *'Teetering on a public health crisis.' New Title X policy forces Ohio Planned Parenthood clinics to close*, USA Today (Sept. 9, 2019), https://bit.ly/2m6OMyG.

pt. 59) ("Rule"). The Rule's referral restrictions and separation requirements were unchanged.

11. Most of the Rule's provisions, including its limitations on referrals, were scheduled to go into effect on May 3, 2019, 84 Fed. Reg. at 7714, and indeed now are in effect nationwide. Compliance with the separation requirement is required by March 4, 2020. *Id.* at 7714.

A. The Counseling Restrictions

12. "The Final Rule imposes broad restrictions on what health care providers under the Title X program may inform pregnant patients." PI Op. at 9. The Rule states that "[a] Title X project may not perform, promote, refer for, or support abortion as a method of family planning, nor take any other affirmative action to assist a patient to secure such an abortion." 84 Fed. Reg. 7,788 (to be codified at 42 C.F.R. §§ 59.5(a)(5), 59.14(a) (abortion-referral ban)). The Rule provides that to meet this requirement Title X grantees may not provide any information about abortion providers, identified as such, to a patient. *Id.*; *see also* PI Op. at 9.

13. The Rule bars trained medical providers, such as registered nurses, from engaging in pregnancy counseling unless they have an advanced degree *and* are licensed to diagnose and treat patients, *i.e.*, qualify as an "advance practice provider." § 59.2.

14. Providers may not provide a patient an abortion referral except in an emergency. If a patient specifically asks for a referral for pregnancy termination during pregnancy counseling, providers are prohibited from offering the patient anything more than a list of "comprehensive primary health care providers"—most of whom must *not* provide any abortions. *Id.* at 7789 The list cannot identify which providers actually provide the abortion services she is requesting, and staff are prohibited from answering patient questions about which providers on the list actually provide abortions. *Id.* Because the list is limited to "comprehensive primary health care providers," specialized reproductive healthcare providers are excluded. *See* PI Op. at 9.

15. In Baltimore, six of the nine providers to whom patients are routinely referred for

abortions are specialized reproductive healthcare providers, which therefore must be excluded from the list. Mobley Decl., PEP375 ¶ 60. The nonspecialized providers permitted on the list are harder for patients to access and may charge thousands of dollars for an abortion, rather than a few hundred. *Id.* ¶¶ 59-60.

16. Even as Title X providers are prohibited from referring for pregnancy termination (even if the patient asks for it) providers are required to refer all pregnant patients for prenatal care (even if the patient has expressly stated she does not want one). 84 Fed. Reg. 7789 (to be codified at 42 C.F.R. §§ 59.14(b)(1)). *See also* PI Op. at 9.

B. Separation Requirement

17. The Rule requires that Title X activities be "physically and financially separate" (defined as having an "objective integrity and independence") from prohibited activities. These "activities" include not just the provision of abortion services, but also any counseling that does not meet the counseling restrictions. 84 Fed. Reg. at 7789; *see also* Op. at 10. Whether this criterion is met is to be determined through a "review of facts and circumstances," with relevant factors including but not limited to:

> (a) The existence of separate, accurate accounting records; (b) The degree of separation from facilities (e.g., treatment, consultation, examination and waiting rooms, office entrances and exits, shared phone numbers, email addresses, educational services, and websites) in which prohibited activities occur and the extent of such prohibited activities; (c) The existence of separate personnel, electronic or paper-based health care records, and workstations; and (d) The extent to which signs and other forms of identification of the Title X project are present, and signs and material referencing or promoting abortion are absent.

Id. The preamble notes that physical separation at a "free-standing clinic," like one of the Baltimore City clinics, "might require more circumstances to be taken into account in order to satisfy a clear separation between Title X services" and abortion referrals, because having the "same entrances, waiting rooms, signage, examination rooms, and the close proximity between Title X

and impermissible services" presents "greater opportunities for confusion" than at a hospital. *Id.* at 7767. The Rule does not specify which additional circumstances would be taken into account.

18. Baltimore City is unable to implement these separation requirements. Hager Decl., PEP389-390 ¶ 34. Compliance with the Rule would therefore prevent Baltimore City healthcare providers working *outside* the Title X program from providing patients with complete and accurate information about all of their medical options, including abortion.

C. The Adolescent Health Restrictions

19. The Rule requires providers to "encourage family participation" in the health services provided to minors, regardless of state laws, such as Maryland's, that explicitly permit minors to consent on their own behalf to treatment for or advice about contraception, pregnancy, sexually transmitted infections, and related care. *Compare* § 59.17 *with* Md. Code Ann. Health-Gen. § 20-102(c). When the provider is aware that family participation would be counter-productive or even dangerous, and that encouraging such participation would be detrimental to the patient, the Rule's requirement to encourage family participation will destroy the delicate trust between Baltimore teenagers and their medical providers, deterring minors from seeking needed healthcare. Mobley Decl., PEP372-373 ¶¶ 50-51; *see id.*, PEP371-372 ¶¶ 40-49.

D. Medical Ethics

20. The Rule requires medical providers to violate medical ethics, including statutory codes of ethics. AMA Comm't, PEP446; AAFP Comm't, PEP459; AAN Comm't, PEP468; ACOG Comm't, PEP586; Stanwood Decl., PEP3-4 ¶ 5; Wynia Decl., PEP324-331 ¶¶ 11-29; Mobley Decl., PEP366-368 21-24; Dzirasa Decl., PEP396 ¶ 10; *see also* Op. at 17-18.

21. HHS has not identified any code of medical ethics under which the Rule's counseling restrictions would be considered ethical. Nor has HHS identified any professional medical organization that takes the position that it is ethical to withhold relevant medical information from a

patient who is requesting it. HHS has not identified a single physician who believes it is consistent with medical ethics for a physician to obstruct a patient's access to safe and legal medical treatment because the physician disagrees with the patient's decision to pursue that treatment.

III. Procedural Irregularities In the Promulgation of the Rule

A. Irregular Procedures and Lack of Adequate Notice

22. The Proposed Rule moved through the Office of Information and Regulatory Affairs (OIRA) at the Office of Management and Budget (OMB)—a process that even for an insignificant rule typically takes months—in less than two weeks. *See* Hassan & Harris Comm't, PEP893; *see also* Lisa Heinzerling, *Classical Administrative Law in the Era of Presidential Administration*, 92 Tex. L. Rev. See Also 171, 174 (2014) (discussing 2013 Administrative Conference of the United States (ACUS) study finding, among other things, that historically rules spend at least 50 days under OIRA review, and in recent years it has been more than 90 days).

23. The Proposed Rule never appeared on the public Fall 2017 or Spring 2018 Regulatory Agendas, *see* Hassan & Harris Comm't, PEP892, even though agencies are supposed to place anticipated regulatory actions on the Agenda twelve months in advance. *See* OMB, *About the Unified Agenda*, PEP956; OIRA, *Memorandum: Spring 2018 Data Call for the Unified Agenda of Federal Regulatory and Deregulatory Actions*, PEP961; *see also* Exec. Order No. 12,866, § 4(b), 58 Fed. Reg. 51,735, 51,738 (Sept. 30, 1993) ("Each agency shall prepare an agenda of all regulations under development or review, at a time and in a manner specified by the Administrator of OIRA").

24. There was no early outreach to affected stakeholders, as required under Executive Order 13563 § 2(c) and associated OMB/OIRA guidance. *See* Hassan & Harris Comm't, PEP892. Despite that lack of public engagement, OMB denied stakeholder groups' requests for meetings during the two weeks the Proposed Rule was under Regulatory Review prior to its proposal in

the Federal Register. *See id*, PEP893.

25. The American Bar Association and ACUS each recommend that agencies give commenters at *minimum* sixty days to prepare and submit comments on a *typical* rule.[6] Christopher J. Walker, *Modernizing the Administrative Procedure Act*, 69 Admin. L. Rev. 629, 641–42 (2017). But those recommendations are framed against the backdrop of the typical regulatory review process. That process often gives regulated parties several months or even years of prior notice. *See* Heinzerling, *supra*, at 174. The additional notice provided by posting proposed regulatory actions on the Regulatory Agenda, and a searching OIRA review, plays a significant role in the adequacy of the typical 60-day comment period. *See* Walker, *supra*, at 645 ("[The] Unified Regulatory Agenda is a *critical resource* for the public to understand an agency's regulatory plans for the near future." (emphasis added)). That additional notice is often necessary for interested parties to fully evaluate the statutory authority for proposed rules; the interaction between proposed rules and other federal, state, and local laws and policies; and the impact and compliance costs associated proposed rules.

26. Numerous commenters, including the Baltimore City Health Department, the State of New York, Planned Parenthood, and two United States Senators, sought extensions of the comment period, informing HHS and OMB that under the comment timeline HHS provided they would be unable to investigate both legal and factual issues necessary to meaningfully

[6] *See* ACUS, Recommendation 2011-2, *Rulemaking Comments*, 76 Fed. Reg. 48,791 (Aug. 9, 2011) ("agencies should use a comment period of *at least* 60 days" for significant regulatory actions (emphasis added)); *see also* ACUS, Recommendation 76-3, Procedures in Addition to Notice & the Opportunity for Comment in Informal Rulemaking (1976) (recommending a second comment period when comments "present new and important issues or serious conflicts of data").

comment.[7] Despite these requests, HHS refused to extend the comment period.

B. Surprise Changes to the Final Rule

27. HHS's Proposed Rule would have allowed only "medical doctors" to engage in pregnancy counseling. *See* 83 Fed. Reg. 25531, 25507, 25518. Numerous commenters explained that many Title X providers are not medical doctors, but instead include, for example, registered nurses, nurse practitioners, and certified nurse midwives, and that (at minimum) the Rule needed to permit these personnel also to provide counseling within the scope of their practice.[8]

28. Rather than adopt these suggestions, HHS adopted a solution that not a single commenter recommended or had an opportunity to comment on, permitting "Advanced Practice Providers" ("APPs") to offer nondirective counseling in addition to medical doctors. 84 Fed. Reg. at 7761. Commenters had no ability to anticipate this change nor any opportunity to explain to the agency why this solution would be insufficient.

STANDARD OF REVIEW

Under Federal Rule of Civil Procedure 56, the Court grants summary judgment "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a); *Celotex Corp. v. Catrett*, 47 U.S. 317, 322 (1986); *Henson v. Graham*, No. CIV.A. RDB-14-2058, 2015 WL 3456778, at *2 (D. Md. May 28, 2015).

[7] *See* Md. Cong. Delegation Comm't, PEP773 (quoting a letter from the Baltimore City Health Department); *see also* Planned Parenthood ("PPFA") Comm't, PEP851; Hassan & Harris Comm't, PEP893; N.Y. State Comm't, PEP462-63; Legal Voice Comm't, at PEP452-54; Governor of Conn. Comm't, PEP450; Universal Healthcare Found. of Conn. Comm't, PEP673.

[8] *See* Maine Family Planning Comm't, PEP430; State Att'ys Gen. Comm't, PEP626; Provide, Inc. Comm't, PEP546; State of Vt. Comm't, PEP479; Worby Comm't, PEP555; Christian Health Care Professional Comm't, PEP455.

ARGUMENT

I. The Rule Is Contrary to Law and Arbitrary and Capricious

A. The Rule Violates the Non-Interference Mandate (Count I)

The Rule violates the Non-Interference Mandate. The Non-Interference Mandate clearly limits HHS's authority: HHS *shall not* promulgate regulations creating unreasonable barriers to health care, requiring doctors to violate medical ethics, or restricting doctors from communicating all relevant information to their patients. *See* 42 U.S.C. § 18114. The Rule's directive counseling requirements and its draconian separation requirements violate the Non-Interference Mandate for the reasons this Court has already explained. PI Op. at 17-18. At minimum, the Rule requires physicians in the Title X program to violate medical ethics in direct contravention of the Mandate. *See id.* And by imposing unnecessary physical and financial separation requirements that most existing Title X providers cannot realistically meet, the Rule violates the Mandate's prohibition on erecting unreasonable barriers to care. *See id.* at 18.

"Waiver" is not an available defense to Baltimore City's Non-Interference Mandate claims. As Defendants have stated, both to this Court and the Fourth Circuit, "nothing stops regulated parties from raising a statutory argument if and when the Secretary applies the rule to them." Defs.' Mot.to Dismiss, ECF 67-1, at 23 (citing *Koretoff v. Vilsack*, 707 F.3d 394, 399 (D.C. Cir. 2013) (per curiam)). Defendants are now applying the Rule to Baltimore City (it is undisputed that the Rule is in effect nationwide). Waiver is therefore no longer an issue in this case.[9]

[9] Additionally, the Rule's violation of the Non-Interference Mandate was not waived and is not subject to waiver. Numerous commenters raised the substance of the issues covered by the Non-Interference Mandate, *see California v. Azar*, 385 F. Supp. 3d 960, 993–95 (N.D. Cal. 2019) (collecting comments), which is sufficient to put an agency on notice of an issue. *See 1000 Friends of Md. v. Browner*, 265 F.3d 216, 228 (4th Cir. 2001). Moreover, purely legal questions, like those raised by the Non-Interference Mandate, are not subject to waiver. *See Cowpasture River Pres. Ass'n v. Forest Serv.*, 911 F.3d 150, 182 (4th Cir. 2018). Finally, the Administrative Record also shows that HHS in fact considered the Non-Interference Mandate in fashioning the

Defendants' other arguments against the Non-Interference Mandate, rejected earlier by the Court, remain unconvincing. The Mandate's "notwithstanding" clause does not limit its reach. *See* PI Op. at 18. The Rule is not ethical or otherwise consistent with the Non-Interference Mandate. And it is immaterial that Title X is a grant program. The Rule still interferes with doctor-patient communications, requires physicians in the program to violate medical ethics, and creates unreasonable barriers for individuals seeking medical care by threatening to withhold funds.

B. The Rule Violates the Nondirective Mandate (Count II)

The Rule violates the Nondirective Mandate. Starting in 1996 (five years after *Rust*), and in every year since, Congress has included a Title X rider in its appropriations acts. *E.g.*, Pub. L. No. 104-134, 110 Stat. 1321-221 (1996); *see also* Continuing Appropriations Act, 2019, P.L. 115-245, Div. B, Title II, §§ 207 and 208 (2018) (the "Nondirective Mandate"). In the rider, Congress mandates "that all pregnancy counseling shall be nondirective." *Id.*

The Court has already determined that the Rule's bar on abortion referrals and its mandatory prenatal referrals each violate the Nondirective Mandate. *See* PI Op. at 18-20. Dictionaries, other statutes, HHS's regulations, usage of the term within the medical field, and HHS's own comments in the preamble to the Rule all show that "nondirective counseling" "encompasses referrals." *Id.* at 19-20; *see California v. Azar*, 385 F. Supp. 3d 960, 986–92 (N.D. Cal. 2019). And, as this Court has held, "[r]equiring providers to refer a patient to prenatal health care even when the patient has expressly stated that she does not want prenatal care is coercive, not 'nondirective.'" PI Op. at 20. Similarly, "[r]equiring providers to provide a referral list" on which a majority of the providers "do not provide abortion, even if the client specifically requests an abortion

Rule, meaning that applying the waiver doctrine—designed to ensure an agency has "an opportunity to consider the matter"—does not make sense here. *1000 Friends of Md.*, 265 F.3d at 228.

referral, is coercive, not 'nondirective.'" *Id.* Additionally, "[r]equiring providers to exclude abortion as one of multiple options available to a client facing an unwanted pregnancy, especially if she has asked about that option, is coercive, not 'nondirective.'" *Id.*

Defendants' counterarguments remain unpersuasive. The Nondirective Mandate does not conflict with *Rust* and therefore does not "supplant" or "impliedly repeal" it. PI Op. at 19; MTD Op. at 13. And requiring health care providers to withhold medically relevant information and to refuse to provide it when asked for is directive.

C. The Rule Violates Title X's Requirement That Title X Services Be "Voluntary" and Non-Coercive (Count III)

The Rule violates Title X's "voluntariness" requirement. That claim was never addressed or analyzed in *Rust* and thus *Rust* does not foreclose it. Title X provides in relevant part that: "The acceptance by any individual of [Title X] family planning services or ... information (including educational materials) ... shall be voluntary." 42 U.S.C. § 300a-5. Since 1980, HHS has understood that provision to mean that Title X grantees must "[p]rovide services without subjecting individuals to any coercion to ... employ or not to employ any particular methods of family planning." 45 Fed. Reg. 37,433, 37,437 (June 3, 1980); *accord* Program Guidelines For Project Grants For Family Planning Services, HHS 5 (Jan. 2001), PEP904 (stating under the headings "5.0 Legal Issues" and "5.1 Voluntary Participation" that "[u]se by any individual of project services must be solely on a voluntary basis. Individuals must not be subjected to coercion to receive services or to use or not to use any particular method of family planning."). HHS's new Rule does not purport to depart from this longstanding interpretation of Title X's voluntariness requirement; indeed, it reaffirms it multiple times. *See* 84 Fed. Reg. at 7724, 7731 ("This final rule continues the historical Title X emphasis that family planning must be voluntary—the definition of 'family planning' adopted by the final rule and, thus, applicable to the Title X program

explicitly states that 'family planning methods and services are never to be coercive and must always be strictly voluntary.'").

The Rule's requirement that providers withhold referrals for pregnancy termination (even when requested) and provide referrals for prenatal care (even when declined)—is *coercive*. It is "coercion to ... employ or not to employ any particular methods of family planning." 45 Fed. Reg. 37,437. As this Court has already explained: "Requiring providers to refer a patient to prenatal health care even when the patient has expressly stated that she does not want prenatal care is *coercive*;" as is "[r]equiring providers to provide a referral list" on which a majority of the providers "do not provide abortion, even if the client specifically requests an abortion referral;" as is "[r]equiring providers to exclude abortion as one of multiple options available to a client facing an unwanted pregnancy, especially if she has asked about that option." PI Op. at 20 (emphasis added). The Rule is thus inconsistent with the unambiguous text of 42 U.S.C. § 300a-5 and inconsistent with HHS's *own* longstanding and unchanged interpretation of that provision.

D. The Rule Is Arbitrary and Capricious Because It Is Inadequately Explained and Substantively Unreasonable (Counts VII & VIII)

The Rule is arbitrary and capricious. The APA requires courts to "hold unlawful and set aside agency action, findings, and conclusions found to be arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." PI Op. at 20-21 (quoting 5 U.S.C. § 706). In reviewing a rule, courts "must engage in a searching and careful inquiry of the [administrative] record, so that we may consider whether the agency considered the relevant factors and whether a clear error of judgment was made." *Id.* at 21 (quoting *Casa De Maryland v. DHS*, 924 F.3d 684, 703 (4th Cir. 2019)). An agency rulemaking is arbitrary and capricious if, in coming to its decision, the agency "relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs

counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Id.* (quoting *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins.*, 463 U.S. 29, 43 (1983)).

Where, "as here, an agency adopts a rule that directly contradicts prior agency conclusions of fact and law, it must acknowledge that it is doing so and give a reasonable justification for the change." *Id.* at 21-22 (citing *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126 (2016)); *accord Casa De Maryland*, 924 F.3d at 703. An agency must justify its decision to adopt a particular interpretation of a statute it administers based on the evidence before it at the time of the rulemaking; the agency cannot simply declare that it believes one interpretation constitutes the "better" interpretation of the statute. *See id.* at 22-23; *see Confederated Tribes of Grand Ronde Cmty. of Or. v. Jewell*, 830 F.3d 552, 559 (D.C. Cir. 2016) ("[A]gency action is always subject to arbitrary and capricious review under the APA, even when it survives *Chevron* Step Two.").

1. Failure to Explain Departure From Prior Interpretation of the Nondirective Mandate

The Rule is arbitrary and capricious because HHS failed to explain or even acknowledge its change in position on the best interpretation of the Nondirective Mandate. In the 2000 Rule, HHS concluded that the Nondirective Mandate *requires* physicians to provide, as a part of pregnancy counseling, when requested, abortion information, including "nondirective counseling and referrals," and that it was adopting that policy *as a result of* the Mandate. 65 Fed. Reg. at 41273. In discussing the "requirement for nondirective counseling and referral," HHS noted that the four most recent appropriations bills "*required* that pregnancy counseling in the Title X program be 'nondirective'" and that "Congress has also repeatedly indicated that it considers this requirement to be an important one." *Id.* (emphasis added). "*Consequently*, the Secretary ... decided to reflect this fundamental program policy in the regulatory text." *Id.* (emphasis added).

HHS further concluded that the Nondirective Mandate *required* the provision of counseling and referral for abortion on request because "totally omitting information on a legal option or removing an option from the client's consideration necessarily steers her toward the options presented and is a *directive* form of counseling." *Id.* (emphasis added). The 2000 preamble states unambiguously that HHS understood the Nondirective Mandate to require nondirective "referral" and concluded that "the regulatory text should reflect the requirement for nondirective counseling and *referral*." *Id.* (emphasis added). In the new Rule, HHS nowhere explains why it reversed its almost 20-year conclusion that the Nondirective Mandate not only permits but *requires* physicians to provide abortion referrals. HHS does not even display an awareness that it is changing its earlier interpretation of the Nondirective Mandate, in contravention of *Encino Motorcars.*

2. Unexplained and Unreasonable Violation of Medical Ethics

The Rule is arbitrary and capricious because HHS's explanation in the preamble—that HHS "disagrees" that the Rule infringes on the legal, ethical, and professional obligations of medical professionals—is inadequately explained and contrary to the evidence before the agency. *See* 84 Fed. Reg. at 7724, 7748. HHS nowhere explains (1) why it departed from its view, expressed in the 2000 Rule, that medical ethics require nondirective counseling and referral, *see* 65 Fed. Reg. 41273-74; (2) why it departed from its own evidence-based assessment of the importance of nondirective counseling and medically appropriate referrals (as reflected in the Quality Family Planning Guidelines that Title X grantees are required to follow and which HHS reaffirmed in the December 2017 QFP Update, Compl. ¶¶ 89-91); and (3) what, if any, evidence the agency had showing that requiring doctors to withhold medically relevant information from patients is consistent with medical ethics. The Rule fails to explain why the agency changed its position on medical ethics and how the evidence before the agency supports its new conclusion.

HHS's cursory statements that it "disagrees" that the Rule violates medical ethics—that is, its implicit conclusion that the Rule *is* consistent with medical ethics, *see* 84 Fed. Reg. at 7724, 7748—are unsupported by any record evidence whatsoever. Major medical organizations including the AMA, ACOG, AAFP, ACP, AAP, AAN, and numerous additional organizations and individuals, all told HHS that the Rule would violate medical ethics and place physicians in an ethically compromised situation. Facts ¶ 9. Four States and Planned Parenthood told HHS that the "the professional and ethical" violations would be so profound "they would be forced to exit the program if the proposed regulations [were] finalized." PPFA Comm't, PEP791.[10] HHS cited no evidence of any kind showing that any organization or even any individual physicians consider the Rule consistent with medical ethics, and there does not appear to be any evidence in the record that would support that conclusion.

Defendants' argument that the Rule necessarily must be ethical because *Rust* upheld a similar counseling restriction is both incorrect and a non-sequitur. So is Defendants' argument that, because Congress has enacted federal conscience statutes, the Rule necessarily must be ethical. Neither *Rust* nor federal conscience statutes can establish the standards of medical ethics. HHS did not say that it chose to enact the Rule *despite* its inconsistency with medical ethics; HHS said that the Rule *is* consistent with medical ethics. Because that is flatly incorrect, and supported by no evidence, the Rule is inadequately justified and arbitrary and capricious.

3. Inadequate Consideration of Reliance Interests and Consequences

The Rule is arbitrary and capricious because HHS inadequately considered the reliance interests that would be disrupted by its abrupt change in agency policy, and because HHS's

[10] In fact, several commenters explained that providers would have to withdraw, and as a result, beneficiaries would have significantly reduced access to care. AMA Comm't, PEP447; ACOG Comm't PEP594-96; AAN Comm't PEP566-67; AAP Comm't, PEP 611-12; PPFA Comm't, PEP791-98; Guttmacher Comm't, PEP656-68.

explanation for its decision to disregard those interests was contrary to the evidence before it. HHS stated in the Rule that "[t]he Department finds *no evidence* to support the assertion that the final rule will drive current providers from the Title X program." 84 Fed. Reg. at 7749 (emphasis added). It stated: "*commenters did not provide evidence* that the rule will negatively impact the quality or accessibility of Title X services. And the Department believes that this rule will likely improve quality and accessibility for Title X services." *Id.* at 7780 (emphasis added). It stated: "[c]ommenters offer *no compelling evidence* that this rule will increase unintended pregnancies or decrease access to contraception." *Id.* at 7785 (emphasis added). It stated that it was "*not aware, either from its own sources or from commenters*, of actual data that could demonstrate a causal connection between the type of changes to Title X regulations contemplated in this rule-making and an increase in unintended pregnancies, births, or costs associated with either." *Id.* at 7775 (emphasis added). HHS asserted its belief that "these final rules will contribute to *more clients being served, gaps in service being closed, and improved client care*." *Id.* at 7723 (emphasis added).

These statements run counter to the evidence before the agency. They are so implausible that they cannot be ascribed to a difference in view or the product of agency expertise. At minimum, the fact that numerous existing Title X providers explained that they would have to withdraw from Title X if the Rule took effect was certainly *some* evidence "supporting the assertion that the final rule [would] drive current providers from the Title X program," 84 Fed. Reg. at 7749—making the agency's assertion that there was "no evidence supporting the assertion" flat wrong.

HHS had before it significant evidence that the Rule would seriously disrupt existing reliance interests, limit access to Title X care, and force an enormous number of providers out of the Title

X program.[11] HHS relied on only one single letter as evidence that new providers would enter the program to fill gaps in services. *See* 84 Fed. Reg. at 7780 & n.138. Commenters not only informed HHS that they would be forced to withdraw from the program because it would require them to violate medical ethics, but also provided HHS with the "actual data" that HHS said it did not have before it, 84 Fed. Reg. at 7780. *See* Brindis Comm't, PEP888-889; PPFA Comm't, PEP857.

Commenters provided HHS with realistic cost estimates for compliance with the separation requirements that showed that HHS's cost estimate was unreasonably low.[12] Evidence provided by commenters showed that HHS's cost estimates were not simply incorrect—but incorrect by *orders of magnitude*. HHS's per site cost estimates for compliance with the separation requirement lack any basis in evidence and are arbitrary and capricious.

Commenters also provided HHS with evidence that—by causing a widespread withdrawal of providers from the Title X program—the Rule would limit access to contraception and other types of reproductive health care, harming women's health. HHS failed to account for these effects because it "[did] not anticipate that there will be a decrease in the overall number of facilities offering services" and that "the net impact on those seeking services from current grantees will be *zero*." 84 Fed. Reg. 7782. That conclusion is so patently contrary to the evidence before the agency that it cannot be ascribed to a reasonable difference of interpretation. Numerous commenters provided HHS with studies showing defunding even one major provider (Planned

[11] Baltimore City Health Dep't Comm't, PEP531; City Health Dep't Leaders Comm't, PEP535; PPFA Comm't, PEP791-96; Guttmacher Comm't PEP565-66; NFPRHA Comm't 723, 727; Ryan Health Comm't PEP660; AMA Comm't PEP447.

[12] *See* Family Planning Council of Iowa Comm't, PEP655 (explaining that cost of establishing a site in Iowa was $85,000); Ctr. Reprod. Rights Comm't, PEP765 (explaining that "the cost of implementing an additional electronic health record system would cost tens of thousands, if not hundreds of thousands of dollars for large practices"); PPFA Comm't, PEP808 (relying on cost estimate studies to estimate average renovation costs of $625,000 for Planned Parenthood sites).

Parenthood) from a generally available grant program severely negatively impacts patient access to care. *See* Brindis Comm't, PEP882, 888-89; PPFA Comm't PEP857. One commenter even provided HHS with a detailed chart showing the impact on contraception access state-by-state if Planned Parenthood alone withdrew from the Title X program. Guttmacher Comm't 557-78. HHS's decision to ignore these impacts was unlawful. *Pub. Citizen v. Fed. Motor Carrier Safety Admin.*, 374 F.3d 1209, 1219 (D.C. Cir. 2004) ("The mere fact that the ... effect[ ] [of a rule] is *uncertain* is no justification for *disregarding* the effect entirely" (emphases in original)). At minimum, HHS's assertions that "*commenters did not provide evidence* that the rule will negatively impact the quality or accessibility of Title X services," 84 Fed. Reg. 7780, and that it was "*not aware, either from its own sources or from commenters*, of actual data that could demonstrate a causal connection between the type of changes to Title X regulations contemplated in this rulemaking and an increase in unintended pregnancies, births, or costs associated with either," *id.* at 7775 (emphasis added), were both contrary to the record before the agency.

Defendants are incorrect that HHS was entitled to disregard the consequences of the Rule because Defendants believe the commenters' warnings about the negative consequences of the Rule were "threats." *See* Mot. Dis., ECF 67-1, at 30; Def. Reply Supp. Mot. Dis., ECF No.72, at 15. Even if HHS had reached that conclusion, it would have been required to explain its reason for reaching it—especially because many of the commenters who raised concerns about the negative health consequences of the Rule were not grantees and had no power to "threaten" the agency. Instead, HHS simply stated without evidence that not only would there be *no* negative consequences as a result of the Rule, in fact the Rule would "contribute to more clients being served, gaps in service being closed, and improved care." 84 Fed. Reg. at 7723. The Rule does not point to any evidence supporting that conclusion, and indeed, no evidence in the record does.

4. Inadequate Consideration and Explanation of Costs and Benefits.

The Rule is arbitrary and capricious because HHS inadequately considered the likely costs and benefits of the physical and financial separation requirement. HHS nowhere meaningfully explains why the previous regulations were inadequate, and—as the record plainly shows—they are not. For decades, those regulations have ensured that Title X funds are not used to provide abortions. The Rule cites no evidence of misuse of funds over the past half-century. Instead, HHS invoked "risk[s]" of "appearance[s]," "perceptions," and "potential" misuse of funds, 84 Fed. Reg. at 7764-65, without pointing to anything to suggest that those risks or perceptions are anything more than rank speculation. In short, HHS devised the Separation Requirement as a solution in to the "risk" of the "appearance" of a nonexistent problem. That does not suffice for reasoned decision-making. *See Natural Res. Def. Council v. EPA*, 859 F.2d 156, 210 (D.C. Cir. 1988).

In addition to citing no quantifiable benefits to the Separation Requirement, the Rule drastically underestimates its costs. HHS estimated that affected grantees will incur average costs of $30,000, but provides no support for that estimate. 84 Fed. Reg. 7782. The *evidence* before the agency, however, showed that this invented number is nowhere close to the actual cost of compliance: Planned Parenthood estimated average capital costs of nearly $625,000 per affected service site. PPFA Comm't, PEP807-08. Furthermore, HHS entirely failed to account for ongoing (not just one-time) costs, including those associated with required duplication of staff and contracts for goods and services—costs that can reach millions of dollars for some grantees.[13]

[13] *See* City Health Dep't Leaders Comm't, PEP535; PPFA Comm't, PEP808-09; Brown Comment, 2-3, https://bit.ly/2PBwvpz.

HHS's estimate of the *number* of affected sites is also obviously and demonstrably wrong. HHS estimated that the total compliance costs for the separation requirement would be $36.08 million, 84 Fed. Reg. at 7782, based on their estimate that 15 percent of sites "do not comply with physical separation requirements" because they provide abortions, combined with their inadequate estimate of $30,000 in compliance costs per site. *Id*. at 7781. HHS's estimate of the number of affected sites should have been closer to 100 percent, because according to Defendants, merely making abortion referrals during pregnancy counseling violates the separation requirement. *See id.* at 7717 (explaining that making a referral for abortion constitutes using abortion as a method of family planning). Because every Title X grantee made abortion referrals before the Rule took effect, the estimated total cost—even using HHS's own per-site number—should have been closer to $240 million than the $36.08 million the agency estimated.

Even though it affects billions of dollars in annual health care expenditures, and the health care systems of every city and State, the Rule is riddled with these sorts of basic errors. Defendants are incorrect that HHS was entitled to select a manifestly irrational estimate of the costs of complying with the separation requirement because the cost of compliance was difficult to quantify. *See Pub. Citizen*, 374 F.3d at 1219. Difficult to quantify or not, HHS's estimated compliance costs are illogical and unsupported on their face and therefore arbitrary and capricious.

5. Unexplained and Irrational Limitation on Who May Engage in Pregnancy Counseling

The Rule's prohibition on pregnancy counseling by any personnel in the Title X Program other than "Advanced Practice Providers" is unexplained and irrational. That change, which excludes a substantial proportion of provider personnel from engaging in pregnancy counseling of any kind, lacks evidentiary support or even a stated rationale. *See* 84 Fed. Reg. at 7716, 7727-

7728. Commenters told HHS that its Proposed Rule—restricting pregnancy counseling to physicians alone—was irrational. HHS's slight modification to its restriction in the Rule is just as irrational. HHS does not contend, and there is no evidence to support the view, that other personnel lack the qualifications for pregnancy counseling. As many commenters explained, before HHS enacted the Rule, a large percentage of patients received pregnancy counseling through nurses and medical assistants without advanced degrees.[14] At minimum, HHS violated the APA by *entirely failing to address* these comments.

E. Failure to Observe Required Procedures (Count IX)

1. HHS Deprived the Public of a Meaningful Opportunity to Comment

The Rule must be vacated and remanded to the agency because the agency failed to give Baltimore City and the public a meaningful opportunity to comment. The APA requires agencies to "give interested persons an opportunity to participate in [a] rule making through submission of written data, views, or arguments." 5 U.S.C. § 553(c). "The important purposes of this notice and comment procedure cannot be overstated." *N.C. Growers' Ass'n, Inc. v. United Farm Workers*, 702 F.3d 755, 763 (4th Cir. 2012). The fundamental question is whether the agency gave interested parties a "meaningful opportunity" to comment. *Id.* at 763, 770; *see Nat'l Lifeline Ass'n v. FCC*, 921 F.3d 1102, 1115 (D.C. Cir. 2019). "That means enough time with enough information to comment." *Prometheus Radio Project v. FCC*, 652 F.3d 431, 450 (3d Cir. 2011).

There is no minimum length for a comment period in the APA. *Petry v. Block*, 737 F.2d 1193, 1201 (D.C. Cir. 1984). Sixty days is generally accepted as the "reasonable *minimum* time for comment" on a typical rule. *Id.* But "there is scarcely anything talismanic about" a "particular

[14] *See* Maine Family Planning Comm't, PEP430; State Att'ys Gen. Comm't, PEP626; Provide, Inc. Comm't, PEP546; State of Vt. Comm't, PEP479; Worby Comm't, PEP555; Christian Health Care Professional Comm't, PEP455.

length of time." *Id.* Even sixty days may be "an inadequate time to allow people to respond to proposals that are complex or based on scientific or technical data." *Id.* at 1201. Where an issue warrants "caution" because of its sensitivity or difficulty "[t]he need for a meaningful comment period" is "particularly acute." *Hollingsworth v. Perry*, 558 U.S. 183, 193 (2010). Courts are "strict in reviewing an agency's compliance with procedural rules" and "in reviewing an agency's procedural integrity, the court relies on its own independent judgment." *Chocolate Mfrs. Ass'n of U.S. v. Block*, 755 F.2d 1098, 1103 (4th Cir. 1985) (internal citations omitted).

HHS deprived the public of a "meaningful opportunity" to comment on the Proposed Rule. HHS radically departed from rulemaking procedures, depriving Baltimore of a meaningful opportunity to comment, by engaging in zero outreach about the Proposed Rule, failing to place the Proposed Rule on the Regulatory Agenda, and rushing the Proposed Rule through OIRA. *See* Facts ¶¶ 22-24. Many commenters thus sought extensions of the comment period. *Id.* ¶ 26.

Lack of notice and opportunity for comment prejudiced Baltimore. The inadequate comment period deprived the public of sufficient opportunity to evaluate and bring to HHS's attention: (1) the statutory authority for the Proposed Rule and the limits on HHS's authority to promulgate it; (2) the interaction of the Proposed Rule with other federal, state, and local laws and policies (e.g., Maryland's laws regarding minor consent, *see* Facts ¶ **Error! Reference source not found.**); (3) the economic impact and compliance costs associated with the Proposed Rule; and (4) the public health impacts of the Proposed Rule. Commenters would have even more squarely raised the Non-Interference Mandate, 42 U.S.C. § 18114, had HHS held the comment period open for a longer period. Commenters would also have marshaled stronger evidence that HHS's cost estimates for the Rule were inaccurate. *See* 84 Fed. Reg. at 7785 (claiming commenters submitted insufficient evidence on the cost estimates of the Rule); *see also id.* at 7781 (similar).

The need for an extended comment period was "particularly acute" in this case. *Hollingsworth*, 558 U.S. at 193. The last time HHS finalized a Rule of this magnitude—the 2000 Rule—it took seven *years*. *See* 65 Fed. Reg. 41270 (July 3, 2000) (final rule); 58 Fed. Reg. 7462 (Feb. 5, 1993) (proposed rule). HHS's Rule would reverse a rule that was seven years in the making and an agency policy that had endured for nearly fifty years. Yet HHS held open the comment period on the new Rule for only two *months*, without giving the public any advance notice that the Rule was even being contemplated. The Rule applies to over $286 million in annual Title X spending and affects the lives of over 4 million low-income Americans, along with health care services provided by every State, and most major cities, including Baltimore City. Title X saves the health care system over $7 billion annually by preventing diseases and unintended pregnancies, and massively reduces the incidence of abortion. Guttmacher Comm't, PEP575. The Proposed Rule was likely to result (and has resulted, Facts ¶ 6) in over forty percent of existing providers leaving the Title X program, along with at least four States. Failure to give parties more than sixty days to investigate the legal and factual basis for the Rule and provide comment to the agency prejudiced Baltimore City.

Defendants are simply incorrect that Baltimore City seeks to layer *additional* procedural requirements on HHS, beyond those already required by the APA. Def. Reply Supp. Mot. Dis., at 17-18. The APA requires that HHS provide commenters a meaningful opportunity to comment. It does not have a prescribed comment period, but rather requires that the length of a comment period be proportional to the complexity and importance of a contemplated rule. The additional notice provided by posting proposed regulatory actions on the Regulatory Agenda, and in-depth OIRA review, plays a significant role in the adequacy of the "typical" 60-day comment period. Here, by *not* engaging in that pre-comment period review, HHS created a need for a longer

comment period to ensure a meaningful opportunity to comment. That does not create any new procedural requirements.

2. The Rule's Restriction of Pregnancy Counseling To Advanced Practice Providers (APPs) Is Not a "Logical Outgrowth" of the Proposed Rule

The Rule's limitations on who may engage in pregnancy counseling is not a "logical outgrowth" of the Proposed Rule. A "final rule the agency adopts must be a logical outgrowth of the rule proposed." *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158, 174 (2007) (citation omitted). The Proposed Rule provided that only physicians would be allowed to engage in pregnancy counseling. Commenters told HHS that numerous other individuals at Title X providers were qualified to engage in pregnancy counseling. Facts ¶ 27. HHS then finalized the Rule by modestly expanding the scope of who may engage in pregnancy counseling, on the basis of educational and professional criteria on which no commenter had an opportunity to comment. Commenters had no way of anticipating that HHS would try to address the limitation the way that it did. Because commenters could not have anticipated HHS's solution, HHS's rule is not a logical outgrowth of the Proposed Rule, and HHS must reopen the comment period to permit commenters to address HHS's proposed solution.

F. The Rule Violates the First Amendment (Count V)

Based on the record now before the Court, the Rule violates the First Amendment for four reasons, none of which are foreclosed by the holding in *Rust*. To be sure, *Rust* upheld the 1988 Rule against a "facial" First Amendment challenge. 500 U.S. at 192-95, 196-200**.** But all four reasons for holding that the *new* Rule violates the First Amendment depend on arguments not addressed or analyzed in *Rust*, facts specific to the new Rule, statutory changes that occurred after *Rust* was decided, or subsequent Supreme Court precedents that bear more directly on the legality of the new Rule than *Rust* does.

First, the Rule violates the First Amendment because it unconstitutionally interferes with the doctor-patient relationship. In *Rust*, the Supreme Court explained that "[i]t could be argued" that "traditional relationships such as that between doctor and patient should enjoy protection under the First Amendment from Government regulation, even when subsidized by the Government." 500 U.S. at 200. But, the Court continued, "[w]e need not resolve that question here, however, because the Title X program regulations do not significantly impinge upon the doctor-patient relationship." *Id.* Unlike the 1988 Rule, the new Rule does "significantly impinge upon the doctor-patient relationship" by destroying the trust that Baltimore's patients have in their doctors. Mobley Decl., PEP371 ¶ 41. Numerous women consider their relationship with their Title X provider to be the most important doctor-patient relationship in their lives, and patients are likely to feel misled and betrayed by their health care provider if the provider refuses to provide necessary and pertinent medical counseling. *Id.* ¶¶ 46-49. That distinguishes the facts here from the facts at issue in *Rust*.

The Supreme Court's holding in *Legal Services Corp. v. Velazquez*, 531 U.S. 533 (2001), makes clear that the Rule unconstitutionally impinges on the doctor-patient relationship. In *Velazquez*, the Court held unconstitutional a law that prohibited federally funded Legal Services lawyers from providing certain advice and making certain legal arguments. *Id.* at 542-43. The Court struck down the provision specifically because lawyers have a professional obligation to represent the interests of their clients. *Id.* As Justice Scalia recognized in his dissent, under the reasoning in *Velazquez*, the Supreme Court should have struck down the 1988 Rule in *Rust* because doctors have a similarly powerful professional obligation to their patients. *Id.* at 554 (Scalia, J., dissenting). The Supreme Court has continually reaffirmed and strengthened the *Velazquez* principle, holding that where the government manipulates the content of professional

speech, especially in a health care setting, its actions must, at minimum, meet intermediate scrutiny—and likely strict scrutiny. *Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2375-76 (2018); *see Sorrell v. IMS Health Inc.*, 564 U.S. 552, 565-66 (2011). Where Supreme Court decisions arguably conflict, lower courts are bound to follow the cases that more directly control. *See, e.g.*, *Waugh Chapel S., LLC v. United Food & Commercial Workers Union Local 27*, 728 F.3d 354, 363-64 (4th Cir. 2013); *Free Speech Coal., Inc. v. Attorney Gen. United States*, 825 F.3d 149, 164 (3d Cir. 2016). Because the Rule prevents physicians from providing professional advice that they believe is in the best interests of their patients, it violates the First Amendment in light of *Velazquez*.

Second, the Rule violates the First Amendment because it unconstitutionally restricts private speech on the basis of its viewpoint. The Supreme Court has clarified in its decisions after *Rust* that the 1988 Rule's restrictions were permissible because Title X was, at that time, a government messaging program, and therefore the regulated speech was "government speech." *See Reed v. Town of Gilbert, Ariz.*, 135 S. Ct. 2218, 2235 (2015) (Breyer, J., concurring); *Walker v. Texas Div., Sons of Confederate Veterans, Inc.*, 135 S. Ct. 2239, 2246 (2015); *Agency for Int'l Dev. v. All. for Open Soc'y Int'l*, 570 U.S. 205, 216-17 (2013); *Velazquez*, 531 U.S. at 540-41; *Rosenberger v. Rector & Visitors of Univ. of Va.*, 515 U.S. 819, 832-33 (1995).

The Supreme Court's later cases leave no doubt that to the extent Title X was a government-messaging program when *Rust* was decided, it no longer is. As the Supreme Court explained recently, courts "must exercise great caution before extending our government-speech precedents." *Matal v. Tam*, 137 S. Ct. 1744, 1758 (2017). "[T]he government-speech doctrine ... is susceptible to dangerous misuse" for "[i]f private speech could be passed off as government speech by simply affixing a government seal of approval, [the] government could silence or muffle the

expression of disfavored viewpoints." *Id.* The Nondirective Mandate and Non-Interference Mandate show that Congress intends to fund "private" physician speech in the Title X program, not "government speech," and therefore that Title X is not a government-messaging program. *See Rosenberger*, 515 U.S. at 834 (holding that where the government creates a program that is not a government-speech program, the government "may not discriminate based on the viewpoint of private persons whose speech it facilitates").

Third, the Rule violates the First Amendment by selectively withholding information from patients on the basis of viewpoint. The Supreme Court has held that the government may not exclude certain disfavored topics or teachers from public school classrooms or remove certain disfavored books from libraries on the basis of their viewpoint. *Bd. of Educ., Island Trees Union Free Sch. Dist. No. 26 v. Pico*, 457 U.S. 853, 870-72 (1982) (plurality) (holding that a school board may not remove books from school libraries on the basis of their viewpoint); *Keyishian v. Bd. of Regents of Univ. of State of N.Y.*, 385 U.S. 589, 603 (1967) (holding that the government may not "cast a pall of orthodoxy over the classroom"); *Meyer v. Nebraska*, 262 U.S. 390, 399-403 (1923). Just as the government may not selectively remove certain viewpoints from government-funded programs—schools and libraries—it may not selectively remove certain viewpoints from government-funded health care services programs. No *Pico* claim was made or analyzed in *Rust* and *Rust* does not speak to it. The Rule "cast[s] a pall of orthodoxy" over Title X providers' discussions with their patients, and therefore the Rule violates the First Amendment. *Keyishian*, 385 U.S. at 603.

Fourth, the Rule violates the First Amendment by violating patients' rights to receive truthful expert information and counsel from their doctors. The First Amendment enshrines a right to "receive information and ideas." *Va. State Bd. Pharm. v. Va. Citizens Consumer Council, Inc.*, 425

U.S. 748, 757 (1976); *Kleindienst v. Mandel*, 408 U.S. 753, 762-63 (1972); *see also First Nat'l Bank of Boston v. Bellotti*, 435 U.S. 765, 783 (1978); *Stanley v. Georgia*, 394 U.S. 557, 564 (1969). The Supreme Court has repeatedly reaffirmed that "people will perceive their own best interests if only they are well enough informed, and ... the best means to that end is to open the channels of communication rather than to close them." *Cent. Hudson Gas & Elec. v. Pub. Serv. Comm'n of N.Y.*, 447 U.S. 557, 562 (1980) (quoting *Va. State Bd. Pharm*, 425 U.S. at 770); *accord Sorrell*, 564 U.S. at 578. "[Z]eal to protect the public from 'too much information' [cannot] withstand First Amendment scrutiny." *Meese v. Keene*, 481 U.S. 465, 482 (1987). This claim was never analyzed in *Rust* and *Rust* does not speak to it. Restricting access to medically relevant information in the Title X program violates the First Amendment by denying patients' rights to receive information.

G. The Rule Violates the Equal Protection Component of the Fifth Amendment's Due Process Clause (Count VI)

Based on the record now before the Court, the Rule violates the Fifth Amendment Due Process Clause's protections against sex discrimination because it targets women for differential treatment from men without an "exceedingly persuasive justification" for doing so. *See United States v. Virginia*, 518 U.S. 515, 531 (1996). Where the government targets one sex for differential treatment, its action must meet intermediate scrutiny. *Id.* at 533; *Miss. Univ. for Women v. Hogan*, 458 U.S. 718, 724 (1982); *accord Sessions v. Morales-Santana*, 137 S. Ct. 1678, 1689-90 (2017); *Nev. Dep't of Human Res. v. Hibbs*, 538 U.S. 721, 728-29 (2003). A rule violates constitutional protection against sex discrimination *either* because it discriminates against women on its face *or* because it was motivated by an unconstitutional purpose to discriminate. *See Pers. Adm'r of Mass. v. Feeney*, 442 U.S. 256, 274 (1979). A sex-discrimination claim was not raised or analyzed or decided in *Rust* and therefore *Rust* does not foreclose this claim. A rule

discriminates against women on its face both (1) when it treats women differently from men; and (2) when it classifies on the basis of pregnancy and in doing so reflects or attempts to enforce sex-role stereotypes. *Hibbs*, 538 U.S. at 730-36; *see id.* at 731 & n.5, 734 & n.6, 736 (2003); *see also Nashville Gas Co. v. Satty*, 434 U.S 136, 142 (1997).

1. The Rule Discriminates Against Women On Its Face Because It Specifically Treats Women Differently From Men

First, the Rule discriminates against women on its face because it treats women and men differently. If a woman seeks advice about her health care treatment options at a Title X clinic, the Rule limits the information or advice she can receive about some of her health care options because she is a woman, and mandates certain referrals. *See* 42 C.F.R. § 59.14. In contrast, if a *man* seeks advice about any of his health care treatment options at a Title X clinic, the Rule places absolutely no restrictions whatsoever on the information or advice he may receive about any medical condition he might have; nor does it mandate any specific referrals.[15]

[15] Specifically, if a woman becomes pregnant, the Rule imposes (1) mandated referral for prenatal care even where a woman refuses the referral; (2) limitations on the types of providers who may provide "nondirective counseling" about abortion; (3) specialized counseling rules prohibiting referrals for abortion, even where a woman requests it. Facts ¶¶ 12-16. The Rule also allows grantees to refuse to provide *any* counseling to a pregnant woman, much less "nondirective" counseling that includes counseling about abortion. 42 C.F.R. § 59.14(b) (indicating that grantees *may*, but are not required to, provide nondirective counseling pregnancy counseling). By contrast, the Rule does not impose on any men seeking reproductive health services: (1) mandated referral for any reproductive health care services, including for men whose partners are pregnant; (2) any limitations on who may provide counseling for reproductive health services; (3) any limitations on the substance of counseling about their own reproductive health care needs, including any referrals they may request for reproductive health care services. *Id.* (no mandated referrals for any reproductive health care men need); *id.* (while counseling "may" be allowed to pregnant women, no counseling is allowed about pregnancy options for men whose partners are pregnant; only women may receive such counseling); *id.* (no limitations on who may counsel men on reproductive health care options). Men are deprived of counseling about pregnancy options and a healthy prenatal environment—information that is important for men whose partners are pregnant, especially when the partner is at higher risk of complications during pregnancy, or where the man undertakes behaviors that could be unhealthy for a developing pregnancy, such as smoking.

2. The Rule Discriminates Against Women On Its Face Because It Classifies On the Basis of Pregnancy Because of the Stereotype That Women Need to Be Protected From Making Bad Family Planning Decisions

The Rule is also an unlawful sex classification because it discriminates on the basis of pregnancy to enforce unconstitutional stereotypes. *See, e.g.*, *Hibbs*, 538 U.S. at 730-36. In *Hibbs*, Chief Justice Rehnquist determined that a pattern of state laws awarding maternity leave to women and not men violated the Equal Protection Clause because the tradition reflected different sex-role expectations of male and female employees. *Hibbs*, 538 U.S. 730-31. *Hibbs* affirmed that a law applicable to pregnancy is sex discrimination subject to heightened scrutiny when it is enacted because of stereotypes rather than physical differences between men and women.[16]

Here, the restrictions on counseling and referrals for pregnant women are not based on "the different physical needs of men and women," *see id.* at 733 n.6, but reflect different sex-role expectations of male and female patients. If a woman visits a Title X clinic and tells her health care provider that she is pregnant, the Rule requires the provider to coerce her into motherhood by prohibiting a referral for abortion, but mandating referral to a prenatal care provider. *See* 42 C.F.R. § 59.14. If a man visits a Title X clinic and tells his health care provider that his wife is pregnant, the Rule does not require the provider to encourage him to become a father, or allow any counseling about healthy pregnancy, much less information about abortion.

The Rule treats pregnant patients differently from other patients because of stereotypes about women. Rules that restrict women's autonomy to end an unwanted pregnancy under the guise of "protecting" them enforce an unlawful stereotype—that women's place is in the home while men are responsible for civic engagement. Haugeberg Decl., PEP10 ¶¶ 15-17 (discussing history of

[16] *See also, e.g., Weisenfeld v. Weinberger*, 420 U.S. 636 (1992); *Frontiero v. Richardson*, 411 U.S. 677 (1973); Cary Franklin, *The Anti-Stereotyping Principle Unconstitutional Sex Discrimination Law*, 85 N.Y.U. L. Rev. 83 (2010).

laws regulating reproductive health care, designed to enforce "women's obligations as wives and mothers", and "women's place in the home"). The Rule, particularly the prohibition on referrals for abortion and the mandatory referral to prenatal care, "resurrect the stereotype that government prioritizes women's identities as mothers or potential mothers." *Id.* PEP41 ¶ 83. Just like old laws restricting information about family planning methods, the Rule reveals "a deep mistrust of women's abilities to make informed and responsible judgments." *Id.* PEP42 ¶ 85; *see id.* PEP19-23 ¶¶ 29-38 (explaining that regulation of abortion and contraception, as well as information about these services, was designed to prevent women from controlling their fertility); *id.* PEP30-31 ¶¶ 57-61 (explaining that Title X was the continuation of an effort in the late 1960s and early 1970s to liberalize access to reproductive health care).

Because the Rule constitutes sex discrimination, the Government must meet heightened scrutiny by coming forward with persuasive *evidence* that there is an "exceedingly persuasive justification" for the Rule that "serves 'important governmental objectives and that the discriminatory means employed' are 'substantially related to the achievement of those objectives.'" *Virginia*, 518 U.S. at 533 (internal citations omitted). That they cannot do. The claim that the Rule is needed to enforce the statutory ban on funding for abortion activities is patently false. Any attempt to justify the Rule as woman-protective is not an exceedingly persuasive justification serving important governmental objectives; nor is it substantially related to the achievement of those objectives. In fact, it is simply further confirmation that the Rule is intended to enforce outdated sex-role stereotypes in violation of the Fifth and Fourteenth Amendments.

II. The Rule is Inseverable

The APA requires that courts "set aside agency action" "not in accordance with law." 5 U.S.C. § 706(2)(A). The test for severability is "essentially an inquiry into ... intent." *Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999); *North Carolina v.*

FERC, 730 F.2d 790, 795–96 (D.C. Cir. 1984) (severability "depends on the issuing agency's intent"). "Severance and affirmance of a portion of an administrative regulation is improper if there is 'substantial doubt' that the agency would have adopted the severed portion on its own." *Davis Cty. Solid Waste Mgmt. v. EPA*, 108 F.3d 1454, 1459 (D.C. Cir. 1997). Severability clauses are rarely decisive of the severability decision. *See Cmty. for Creative Non-Violence v. Turner*, 893 F.2d 1387, 1394 (D.C. Cir. 1990). A court should set aside a rule where upholding only a portion of the rule would result in "a scheme sharply different from what" the agency contemplated, *Murphy v. NCAA*, 138 S. Ct. 1461, 1482 (2018). This is especially true because the agency is best positioned to respond to the court's ruling by crafting a new rule through notice and comment. If this Court deems either the Rule's counseling restrictions or its separation requirements—or both—to be unlawful, it should set aside the Rule. In light of the centrality and importance of those provisions there is "substantial doubt" that the agency would have promulgated the Rule in the absence of one or both of those central provisions.

CONCLUSION

For the foregoing reasons, Plaintiff respectfully requests that the Court grant Plaintiff's Motion for Summary Judgment.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on November 1, 2019, I filed the foregoing with the Clerk of the Court using the ECF System which will send notification of such filing to the registered participants identified on the Notice of Electronic Filing.

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