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UNITED STATES DISTRICT COURT

DISTRICT OF OREGON

EUGENE DIVISION

STATE OF OREGON et al., Plaintiffs, v. ALEX M. AZAR II et al., Defendants.	Case No. 19-cv-00317-MC (Lead Case) Case No. 6:19-cv-00318-MC (Trailing Case) PLAINTIFFS' REPLY IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION Pursuant to Fed. R. Civ. P. 65 Oral Argument Date: April 23, 2019
AMERICAN MEDICAL ASSOCIATION et al., Plaintiffs, v. ALEX M. AZAR II et al., Defendants.	

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

CASES

STATUTES

RULES & REGULATIONS

OTHER AUTHORITIES

COMMENT LETTERS

INTRODUCTION

HHS has issued a Final Rule that would warp and decimate the Title X program. As Plaintiffs have detailed, the Rule would cause immediate and irreparable harm to patients and providers and would politicize the practice of medicine and delivery of health care. Fourteen days from now, Planned Parenthood—which serves 40% of all Title X patients, or more than 1.5 million individuals—will be forced to drop out of Title X rather than comply with a Rule that would harm patients and would force its practitioners to violate their ethical codes. HHS attempts to dismiss any harms as "speculative predictions" (Opp. 4, Dkt. 90), but these harms are well documented in the administrative record and in Plaintiffs' declarations.

On the merits, HHS relies principally on *Rust v. Sullivan*, 500 U.S. 173 (1991), claiming the Final Rule cannot be unlawful because it is similar in many respects to the 1988 rule upheld in *Rust*. As the government would have it, this case is merely *Rust* redux, nothing important has happened in the 27 years since *Rust*, and any argument to the contrary seeks to "impliedly repeal" *Rust*, § 1008 of Title X (codified at 42 U.S.C. § 300a-6), or both.

That argument fundamentally misreads both *Rust* and Plaintiffs' argument. Plaintiffs do not dispute that the terms of the 1988 rule and the Final Rule are similar. But *Rust* held only that § 1008 of Title X was "ambiguous," and that the 1988 rule was a "plausible" construction of the statute, 500 U.S. at 184. What is different, and dispositive today, is the governing law. This case is controlled by a statutory structure Congress put in place after *Rust*—namely, the Nondirective Mandate and 42 U.S.C. § 18114. Those provisions significantly change the governing law, but they are in harmony with § 1008 and raise no issue of implied repeal.

In the Nondirective Mandate, Congress has specified that "all pregnancy counseling" under Title X must be "nondirective." *E.g.*, Pub. L. No. 115-245, 132 Stat. 2981, 3070-3071 (2018); Pub. L. No. 104-134, 110 Stat. 1321-221 (1996). HHS concedes the following: First,

the Nondirective Mandate went into effect after *Rust* and added requirements to Title X; second, HHS is bound by its terms; and third, those terms require, upon a patient's request, the presentation of *all* medically appropriate options without suggesting or advising one option over another. The only question here is whether the Gag Requirement complies with that mandate, and the answer is no. By design, the Gag Requirement seeks to steer a pregnant patient away from one option, abortion, and toward another, carrying a pregnancy to term. To turn the government's phrase, that is the "paradigm" of "[]directive" counseling (Opp. 24).

As for 42 U.S.C. § 18114 of the Affordable Care Act, HHS never takes on its plain terms. That is with good reason. They clearly proscribe the Final Rule. Instead, HHS seeks to avoid those terms by arguing that the statute is inapplicable. HHS's lead argument, for example, is that Plaintiffs' § 18114 challenge is waived because it was not cited in comments on the proposed rule. But Plaintiffs (and many other commenters) clearly put HHS on notice that its proposal violated every single prohibition of § 18114; whether they cited this section of the ACA is irrelevant. More fundamentally, the waiver principle does not apply where, as here, the scope of the agency's power to act is concerned.

The Final Rule is also arbitrary and capricious in numerous respects. Above all, HHS fails to account for the fact that the Final Rule contravenes the ethical and professional commitments of doctors, nurses, and other health care professionals, and, as a result, will lead to a mass exodus of providers from Title X. That exodus will have grave public health consequences, leading to major gaps in access to care and harm to public health. As in the Final Rule, the government's opposition ignores or sweeps away those problems without evidence. It simply repeats the unsupported point that the Final Rule "would 'contribute to more clients being served, gaps in service being closed, and improved client care'" (Opp. 46). And HHS *still*

identifies no discernible public health benefit of its radical approach.

The government does not dispute that it seeks to change the way the Title X program has functioned with great success for nearly 50 years. There is no harm in preserving the status quo. But absent injunctive relief, a national public health crisis will follow in short order. Thus, for the foregoing reasons, and those previously stated, the Court should grant Plaintiffs' motion and enjoin the Final Rule in its entirety.

ARGUMENT

I. Plaintiffs Are Likely To Succeed On The Merits

A. The Final Rule Is Contrary To Federal Law

Congress has mandated that "all pregnancy counseling" under Title X be "nondirective," Pub. L. No. 115-245, 132 Stat. 2981, 3070-3071 (2018), and has prohibited HHS from issuing "any regulation" that, among other things, interferes with communications between a medical provider and her patient or creates unreasonable barriers to appropriate medical care, 42 U.S.C. § 18114. Each of these enactments independently dooms the Final Rule. The Gag Requirement is necessarily directive—by design, it steers a pregnant patient toward carrying the pregnancy to term. And the Gag and Separation Requirements do exactly what § 18114 proscribes.

1. The Gag Requirement violates the Nondirective Mandate

The Gag Requirement *bans* referrals for abortion but *mandates* referrals for prenatal care, regardless of what a patient wants. 84 Fed. Reg. 7,714, 7,788, 7,789 (Mar. 4, 2019). Thus, Title X providers must *not* tell pregnant patients how and where they can obtain abortion services, but *must* provide that information as to prenatal care. Moreover, even when a patient says she is interested in an abortion *only*, practitioners must disregard that decision, speak to the patient about other options she *does not want*, and tell her about the "risks and side effects to both [her] and unborn child." *Id.* at 7,747; *see id.* ("abortion must not be the only option presented").

HHS does not dispute that the Final Rule operates just as Plaintiffs have described it. *See* Opp. 11-12. The parties dispute only whether those requirements run afoul of the Nondirective Mandate. But in that connection, HHS concedes the following: (1) the Nondirective Mandate went into effect after *Rust* and "imposed additional requirements on [the Title X program]," 84 Fed. Reg. at 7,720; *see* Opp. 2, 14; (2) the agency is bound by its terms, 84 Fed. Reg. at 7,747; Opp. 17-18; and (3) those terms require, upon a patient's request, the presentation of all medically appropriate options without "'suggesting or advising one option over another,'" 84 Fed. Reg. at 7,716. In view of those concessions, the Gag Requirement is inconsistent with the Nondirective Mandate.

a. *Rust does not control, and this case does not involve implied repeal*

HHS invokes *Rust* and argues that Plaintiffs seek to impliedly repeal § 1008, *Rust*, or both. *See, e.g.*, Opp. 10-23. That is incorrect.

In *Rust*, the Supreme Court concluded that "[t]he language of § 1008" was "ambiguous." 500 U.S. at 184. Section 1008, the Court explained, "does not speak directly to the issues of counseling, referral, advocacy, or program integrity" and "the legislative history is ambiguous and fails to shed light on relevant congressional intent." *Id.* at 185. The question before the Court, then, was whether HHS's construction of that "ambiguous" statute was "plausible." *Id.* The Court concluded only that it was "unable to say that the Secretary's construction of the prohibition in § 1008 to require a ban on counseling, referral, and advocacy within the Title X program is impermissible." *Id.* at 184; *see id.* at 188 ("program integrity requirements are based on a permissible construction"); *accord* Opp. 7 (*Rust* held that the 1988 rule was "permissible.").

Four years after *Rust*, in 1996, and every year since then, Congress has included a Title X rider in its appropriations acts. *E.g.*, Pub. L. No. 104-134, 110 Stat. 1321-221 (1996). There,

Congress mandated (1) "[t]hat amounts provided to said projects under [Title X] shall not be expended for abortions," and (2) "that all pregnancy counseling shall be nondirective." *Id.*

This appropriations act language does not repeal § 1008 or *Rust*; rather, it defines the parameters of HHS's exercise of delegated discretion. Again, *Rust* held that § 1008 was ambiguous, thereby delegating authority to HHS to construe the statute. *Rust* then held that HHS's ban on counseling and referral was not impermissible; in other words, § 1008 did not bar the agency from doing what it did in the 1988 rule. That *Rust* interpreted § 1008 not to forbid a ban on counseling and referral for abortion in the 1988 rule surely does not mean that, when Congress later chose to enact the Nondirective Mandate forbidding HHS from exercising its authority in that way, it is impliedly or explicitly repealing § 1008. Section 1008 (which does not speak to counseling and referral, but does speak to the funding of abortion) is still operative. The Nondirective Mandate is simply doing something § 1008 did not—cabining the scope of HHS's authority when pregnancy counseling is concerned.

Indeed, while repeatedly arguing against "implied repeal" (*e.g.*, Opp. 2, 17, 19, 21, 22), HHS has repeatedly admitted that the Nondirective Mandate *did* materially alter Title X—in HHS's own words, it "imposed *additional requirements*" on the Title X program, 84 Fed. Reg. at 7,720 (emphasis added). Thus, as HHS acknowledges in the Final Rule, "projects must comply with Congress's requirement that pregnancy counseling be nondirective, and the Department must enforce that requirement." *Id.* at 7,747. "In subsequent years" after *Rust*, HHS also acknowledges, "Congress has indicated that nondirective postconception counseling would be permissible … through appropriations law provisions requiring that any pregnancy counseling offered in Title X projects be nondirective." *Id.* at 7,760; *see also id.* at 7,725 ("permission for nondirective pregnancy counseling … implements an appropriations rider that was adopted as

early as 1996" but which "did not exist at the time the 1988 regulations were adopted"). HHS's brief is to the same effect. *See* Opp. 17, 19. Thus, as HHS has repeatedly admitted, the Nondirective Mandate *did* change the law, and under the current law the Gag Requirement must fall.

HHS's implied-repeal argument fails for another reason too. Implied repeal is an interpretive tool that dictates that a court should not read two statutory provisions to be in irreconcilable conflict, such that the later statute impliedly repeals the earlier, "unless the later statute expressly contradicts the original act or unless such a construction is absolutely necessary in order that the words of the later statute shall have any meaning at all." *National Ass'n of Home Builders v. Defenders of Wildlife*, 551 U.S. 644, 662 (2007) (internal quotation marks and alterations omitted). Here, as discussed, there is no conflict.

The implied-repeal cases HHS cites provide it no help. *See* Opp. 17-18. In *National Association of Home Builders*, 551 U.S. at 661, for example, the Supreme Court construed the Endangered Species Act so as not to create an "irreconcilable" conflict with the Clean Water Act. As explained, the Nondirective Mandate does not create any conflict; it simply does something that § 1008 did not do. And in *TC Heartland LLC v. Kraft Foods Group Brands LLC*, 137 S. Ct. 1514, 1520, 1521 (2017), the Court rejected the assertion that Congress had implicitly changed the meaning of a term ("reside") after the Court had "definitively and unambiguously held that [it] ha[d] a particular meaning." *Id.* at 1516. *Rust* specifically held that the restriction in § 1008 did *not* have a particular meaning.

HHS's arguments concerning the effect of appropriations acts (*see* Opp. 19-20) are similarly unavailing. "[A]ppropriations acts are 'Acts of Congress' that can change substantive law." *Tin Cup, LLC v. U.S. Army Corps of Eng'rs*, 904 F.3d 1068, 1072-1073 (9th Cir. 2018),

petition for cert. filed (Dec. 18, 2018). And contrary to HHS's submission, there is no general rule that requires construing appropriations acts narrowly. *Cf. Calloway v. District of Columbia*, 216 F.3d 1, 9 (D.C. Cir. 2000) ("*when appropriations measures arguably conflict with the underlying authorizing legislation*, their effect must be construed narrowly" (emphasis added)).

b. *HHS's other arguments about the Nondirective Mandate fail*

HHS also argues that the Gag Requirement is consistent with the Nondirective Mandate. Banning abortion referrals while mandating prenatal referrals, HHS contends, has nothing to do with the Nondirective Mandate because that provision "concerns counseling, not referrals." Opp. 23. And requiring that providers counsel on other non-abortion options in *all* instances—even where a patient has stated that she is not interested in those options—is, according to the government, "the paradigm of nondirective counseling." Opp. 24. Those arguments fail.

As Plaintiffs previously explained, nondirective counseling under Title X includes referrals upon request; that practice accords with core medical principles and HHS's own instructions. Mot. 16; *see, e.g.*, *Alabama Power Co. v. EPA*, 40 F.3d 450, 454 (D.C. Cir. 1994) ("[W]here Congress has used technical words or terms of art, it is proper to explain them by referring to the art or science to which they are appropriate.").

As Dr. Thomas Ewing described, for example:

> Referrals are an integral part of counseling and the fundamental medical principle of continuity of care. Counseling is more effective when I provide a patient, upon request, with the opportunity to obtain all relevant information about any of her options. That includes a referral—that is, information about how and where the patient can receive a particular course of treatment.

Ewing Decl. ¶ 33, Dkt. 46. That description accords with HHS's evidence-based clinical recommendations, as set forth in its Quality Family Planning standards. *See* Mot. 24. When a health care provider tells a patient that she is pregnant, HHS has instructed, the provider should provide "[o]ptions counseling … in accordance with the recommendations from professional

medical associations, such as [the American College of Gynecologists and American Academy of Pediatrics]. CDC, *Providing Quality Family Planning Services* 14 (2014). "Both ACOG and AAP are explicit in their recommendations that all pregnant individuals … be provided with … nondirective pregnancy options counseling that includes … timely referral[.]'" Kost Decl. ¶ 25, Dkt. 53.

HHS insists otherwise in its brief, drawing a line between "counseling" and "referral." But in the Final Rule, HHS repeatedly embraces the opposite position—that "referral" is "part of nondirective … counseling." 84 Fed. Reg. at 7,733, 7,734.[1] Congress has confirmed the same. In creating the Infant Adoption Awareness Training Program, repeatedly cited in the Final Rule, *see, e.g.*, 84 Fed. Reg. at 7,730, 7,733, 7,744, Congress instructed HHS to make grants to train staff of eligible health centers "in providing adoption information *and referrals* to pregnant women on an equal basis with all other courses of action *included in nondirective counseling* to pregnant women." 42 U.S.C. § 254c-6(a)(1) (emphasis added). In short, both Congress and the responsible agency disagree that counseling and referrals are separate practices, subject to distinct statutory requirements.[2]

---

[1] *See* 84 Fed. Reg. at 7,730 ("nondirective pregnancy counseling can include counseling on adoption, *and corresponding referrals* to adoption agencies"); *id.* at 7,733 ("Congress has expressed its intent that postconception adoption information *and referrals be included as part of any nondirective counseling* in Title X projects[.]"); *id.* at 7,734 ("may facilitate access to adoption through nondirective adoption counseling *and referral as a part of the nondirective counseling* offered to pregnant clients"); *id.* at 7,744 ("may provide adoption information *and referrals during postconception pregnancy counseling*"); *id.* at 7,747 (referencing "referrals made … during [nondirective pregnancy] counseling").

[2] The government cites unenacted legislation, the Family Planning Amendment Acts of 1992, in support of its point that counseling and referrals are distinct. Opp. 22. But, "of course, 'it is the enacted text rather than the unenacted legislative history that prevails.'" *Cohen v. United States*, 650 F.3d 717, 730 (D.C. Cir. 2011). And even if the Court were to consider this failed enactment, nothing can be discerned here from Congress's use of different language in the Nondirective Mandate, four years after the 1992 bill was vetoed.

Even if the Court were to agree with the government's litigation position that referrals are not necessarily "part of" counseling—that is, assuming a provider can provide comprehensive pregnancy counseling without telling a patient where and how she can access a particular course of treatment—providing referrals in the way required by the Final Rule renders a provider's counseling directive, and so impermissible under the Nondirective Mandate. An example may be helpful.

Michele Megregian is a certified-nurse midwife with more than 20 years of experience in the Title X program. As she explained in her declaration, nondirective pregnancy counseling typically arises out of a visit for a pregnancy test. Megregian Decl. ¶ 22, Dkt. 47. Upon determining that a patient is pregnant, Ms. Megregian will offer her patient the opportunity to receive information on prenatal care and delivery; infant care, foster care, or adoption; and abortion. How Ms. Megregian and her patient proceed from there—that is, whether she discusses any options or provides any referrals—"depends on what the *patient* requests." *Id.* (emphasis added). The Final Rule would radically change that *patient*-driven approach, and would require that Ms. Megregian provide a referral for prenatal care but not provide a referral for abortion, regardless of what her patient wants. By definition, the patient is being steered toward one option over another. *See, e.g.*, *id.* ¶ 25. And it beggars belief that Congress would require Title X practitioners to provide "nondirective counseling" regarding a pregnant woman's options, but then require concluding the visit by telling the patient where and how she can obtain a particular treatment option of *the government's* preference. Congress surely did not intend for Title X providers to be able to check off a nondirective-counseling box and then tell the patient exactly whom she should see for the *government's* preferred treatment.

The Final Rule requires directive counseling in another way too. The Gag Requirement

mandates that Title X projects *always* counsel patients on prenatal care or adoption, even when a patient says she is not interested. *See* Mot. 16-17. The government argues that "discussing multiple options with a patient … is the paradigm of nondirective counseling." Opp. 24. HHS misses the point. Nondirective counseling is not about how *much* information is discussed, whether it is "multiple options" (Opp. 24) or just one. Rather, as HHS acknowledged in the Final Rule, "[n]ondirective counseling … [means] that *clients* take an active role in processing their experiences and *identifying the direction of the interaction*," thereby "promot[ing] the [patient's] self-awareness and empower[ing] the [patient] to be informed about a range of options." 84 Fed. Reg. at 7,714 (emphasis added). Put simply, nondirective counseling allows *the patient* to make the choice about what information *she wants to receive*. *See, e.g.*, *id.*; NFPRHA Comment Ltr. 5 (July 31, 2018); EAH Comment Ltr. 4 (July 30, 2018); AMA Comment Ltr. 2 (July 31, 2018). That accords precisely with the central tenet of the medical profession. As Dr. Madara stated on behalf of the AMA here: "Beneficence to the patient is the primary aim of the medical profession." Madara Decl. ¶ 10, Dkt. 49.

If a woman has decided to have an abortion, and states she does not want information about prenatal care or adoption, providing that information despite the patient's wishes is directive. HHS has previously acknowledged just that: "If projects were to counsel on an option even where a client indicated that she did not want to consider that option, there would be a real question as to whether the counseling was truly nondirective or whether the client was being steered to choose a particular option." 65 Fed. Reg. at 41,273; *see, e.g.*, Madara Decl. ¶ 26 (counseling contrary to a patient's express instruction "is directive counseling").

2. The Gag Requirement and Separation Requirement violate 42 U.S.C. § 18114

The Gag Requirement fails for another reason, and so does the Separation Requirement.

Both violate 42 U.S.C. § 18114. *See* Mot. 17-19, 26, 33-35.

> In that statute, enacted nearly two decades after *Rust*, Congress declared that HHS
>
> *shall not promulgate any regulation* that—(1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care; (2) impedes timely access to health care services; (3) interferes with communications regarding a full range of treatment options between the patient and the provider; (4) restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions; (5) violates the principles of informed consent and the ethical standards of health care professionals; or (6) limits the availability of health care treatment for the full duration of a patient's medical needs.

Pub. L. No. 111-148, § 1554, 124 Stat. 259 (emphasis added) (codified at 42 U.S.C. § 18114). The Final Rule violates this statute in every respect. HHS does not defend the Final Rule as permissible under this statute, but instead argues that the statute does not apply to Title X at all. That contention is meritless.

a. *Plaintiffs' § 18114 challenge is not waived*

HHS first argues that Plaintiffs' challenge under § 18114 is waived because Plaintiffs did not cite that section during the comment period. *See* Opp. 25-26. But Plaintiffs and numerous other commenters clearly put HHS on specific notice that the proposal ran afoul of each prohibition § 18114 entails. As Planned Parenthood stated in its comments, for example, the proposed rule would "contravene the ethical and professional commitments of health care providers," "harm patients seeking abortions by introducing extraordinary difficulties into the already arduous process of obtaining one," and cause patients "to delay or forgo basic preventive services." PPFA Comment Ltr. 10, 20, 33 (July 31, 2018).[3] There is no requirement that

[3] Going through each prohibition in § 18114 one by one, commenters repeatedly raised these issues during the comment period: *1. Unreasonable Barriers to Care*. *See, e.g.*, Attorneys General for California et al. Comment Ltr. 4, 6 (July 30, 2018) (proposed rule "seeks to create barriers to access to women's healthcare"; "[t]hese government-imposed barriers to the physician-patient relationship interfere with the provision of medical care and will impede public

commenters specifically cite the U.S. Code provision a proposed rule offends. *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").

In any event, the waiver rule is inapplicable here. Section 18114 prohibits HHS from issuing "any regulation" that violates it terms. The waiver rule HHS invokes "does not apply to preclude argument where the scope of the agency's power to act is concerned." *Sierra Club v. Pruitt*, 293 F. Supp. 3d 1050, 1061 (N.D. Cal. 2018). Where a federal law proscribes an agency from acting in the way that it did, there is no reason to give that action a pass because a party did not object in a comment. And even if waiver were applicable, it is a prudential doctrine that will not be enforced where, as here, "exceptional circumstances" exist. *Universal Health Servs., Inc. v. Thompson*, 363 F.3d 1013, 1021 (9th Cir. 2004). Balancing the agency's interests against the Plaintiffs, HHS nowhere suggests that it has suffered harm from not being able to "correct[] its own errors" or "mak[e] a proper record." *Id.* Plaintiffs, by contrast, have a substantial interest in ensuring that HHS does not implement regulations that harm patient care. Finally, the

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health"). *2. Impediments to Timely Access to Care*. *See, e.g.*, Center for Reproductive Rights Comment Ltr. (CRR) 12 (July 31, 2018) ("The proposed rule would result in medically unnecessary and inappropriate delays in care[.]"). *3. Interference with Patient-Provider Communications*. *See, e.g.*, AMA Comment Ltr. 1 (proposed rule "dangerously interfere[s] with the patient-physician relationship"); American College of Nurse-Midwives Comment Ltr. 2 (July 31, 2018) ("proposed rule limits how Title X providers can discuss and/or counsel on the full-range of sexual and reproductive health care options"). *4. Restrictions on Full Disclosure of Relevant Information. See, e.g.*, CRR Comment 41 (proposed rule "undermines the right to information by censoring health care providers from informing patients of all their options related to abortion"). *5. Violation of Ethical Standards*. *See, e.g.*, AMA Comment Ltr. 1 (proposed rule "conflict[s] with physicians' ethical obligations"). *6. Limitation of Availability of Health Care Treatment for the Full Duration of a Patient's Needs. See, e.g.*, American Public Health Association Comment Ltr. 3 (July 30, 2018) ("Limiting support for comprehensive reproductive health services takes us back to failed policies that harm women's health.").

government does not suggest HHS would have done anything differently had § 18114 been cited during the comment period; indeed, it argues in its brief that § 18114 does not apply to Title X at all. Thus, citing that statute in comments would have been futile.[4]

b. *HHS's other efforts to avoid § 18114 fail*

1. HHS asserts that Plaintiffs' § 18114 argument is "fundamental[ly] implausib[e]," invoking the "basic principle" that one "'does not … hide elephants in mouseholes.'" Opp. 26. Neither the ACA, nor § 18114 in particular, is a "mousehole." The ACA was *intended* to overhaul the American health care system. The Act stretches "over 900 pages and contains hundreds of provisions," and its central aims were "to increase the number of Americans covered by health insurance and decrease the cost of health care." *National Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538-539 (2012). Section 18114 advances the ACA's objectives with a forceful prohibition on agency action that harms patient care as set forth in six specific provisions.

HHS also expresses skepticism that Congress would have effected a change to Title X without "mention[ing] abortion, pregnancy, Title X, section 1008, or *Rust*." Opp. 26. But when Congress limits an agency's regulatory authority wholesale, as it has done through § 18114, Congress need not mention every program that agency administers. *See, e.g.*, *PGA Tour, Inc. v. Martin*, 532 U.S. 661, 689 (2001) ("[T]he fact that a statute can be applied in situations not expressly anticipated by Congress does not demonstrate ambiguity. It demonstrates breadth."); *Oncale v. Sundowner Offshore Servs., Inc.*, 523 U.S. 75, 79 (1998) ("[S]tatutory prohibitions often go beyond the principal evil to cover reasonably comparable evils[.]"). HHS's argument

[4] The government does not claim to be have been unaware of this provision, and it could not do so. HHS analyzed § 18114 in its recent rulemaking regarding the contraceptive coverage mandate. *See* 83 Fed. Reg. 57,536, 57,552 (Nov. 15, 2018).

amounts to the proposition that a generally applicable limitation on an agency's authority is no limitation at all. That is incorrect. *See Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988) ("It is axiomatic that an administrative agency's power to promulgate legislative regulations is limited to the authority delegated by Congress.").

2. HHS again invokes the presumption against implied repeals (Opp. 26-27), but that argument fails for the same reasons discussed above with regard to the Nondirective Mandate. *See supra* pp. 4-6. This case does not involve any issue of implied repeal, and it is Plaintiffs' interpretation that gives effect to both § 1008 and § 18114. The general-specific canon (*see* Opp. 29) is uninformative for a similar reason. This is not a case "in which a general permission or prohibition is contradicted by a specific prohibition or permission." *RadLAX Gateway Hotel, LLC v. Amalgamated Bank*, 566 U.S. 639, 645 (2012). The two statutes are addressed to different things. Section 1008 provides that Title X funds shall not "be used in programs where abortion is a method of family planning," and § 18114 instructs HHS to implement that prohibition in such a manner that does not, for example, "interfere[] with communications regarding a full range of treatment options between the patient and the provider." The current regulations satisfy both of those statutes; the Final Rule does not.

3. HHS suggests that there is a "substantial question" whether § 18114 claims are reviewable under the APA because the statute purportedly creates an "open-ended" standard. Opp. 28. But the government is unwilling to say that the standard is nonjusticiable, and for good reason. That "very narrow" exception—applicable only "in those rare instances" where "there is no law to apply"—does not apply. *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 410 (1971). Section 18114 is no more "open-ended" than many other statutes found subject to judicial review. *See, e.g.*, *id.* at 410-413 (rejecting nonjusticiablility challenge to a "feasible

and prudent" statutory standard). Far from an "open-ended" standard, § 18114 identifies six particular ways in which HHS regulations may not interfere with patient care.

4. Again invoking *Rust*, HHS argues that § 18114 does not apply to regulations concerning government-funded programs because § 18114 concerns only "the *denial* of information or services to patients." Opp. 27. The part of *Rust* on which the government relies concerned whether the 1988 rule impermissibly burdened constitutional rights under the unconstitutional-conditions doctrine; it has no bearing on how to interpret a statute enacted nearly two decades later. And as to that statute, § 18114 contains no such government-funding limitation. By its plain terms, § 18114 applies to "any regulation" issued by HHS.

5. The government errs in arguing that § 18114 only limits HHS regulations issued under authority granted by the ACA. *See* Opp. 28. Again, the statute applies to "any regulation" issued by HHS. Moreover, § 18114 is located in a subchapter with another broadly applicable provision that HHS confirms applies to all federal health care programs. *See* 42 U.S.C. § 18116 (prohibiting discrimination by "*any* health program or activity, any part of which is receiving Federal financial assistance" (emphasis added)); 45 C.F.R. § 92.2 (nondiscrimination provision in § 18116 "applies to *every* health program or activity" that receives federal financial assistance or is administered by HHS (emphasis added)). Congress knows how to limit the applicability of a restriction when it wants to do so. The immediately preceding section of the statute shows Congress doing just that. *See* 42 U.S.C. § 18113 ("The Federal Government, and any State or local government or health care provider that receives Federal financial assistance *under this Act* … or any health plan created *under this Act* …, may not subject an individual or institutional health care entity to discrimination on the basis that the entity does not provide any" health care item or service for use in assisted suicide).

HHS is also wrong that § 18114's "notwithstanding" clause limits the statute's applicability. That clause explains how § 18114 should be read *in relation to other provisions of the ACA*; that is, it "signals the drafter's intention that the provisions" of § 18114 "override conflicting provisions of any other section" of the ACA. *Field v. Napolitano*, 663 F.3d 505, 511 (1st Cir. 2011). The clause does not define the limits of § 18114's applicability. If Congress had wanted to do that, it would have said: "The Secretary of Health and Human Services shall not promulgate any regulation *under this Act* that" impedes access to health care. *Cf.* 50 U.S.C. § 3812 ("*Notwithstanding the foregoing sentence*, no regulation *issued under this Act* shall become effective until the expiration of thirty days following the date on which such regulation has been published in the Federal Register." (emphasis added)).

B. The Final Rule Is Arbitrary And Capricious

The Final Rule is arbitrary and capricious for numerous reasons. Among other things, HHS failed to consider the Rule's effects on Title X providers, patients, or the public health, and ignored evidence showing that the cost of compliance would be vastly more than HHS estimated. *See* Mot. 20-24, 27-28, 36-40.[5]

HHS's opposition, like the Final Rule, largely ignores these arguments and ignores the administrative record. *See* Opp. 31-50. The government returns to *Rust* and argues that any arbitrary-and-capricious argument is foreclosed because similar regulations were upheld in 1991. Yet again, that misses the point. *Rust*'s conclusion, in 1991, that the 1988 rules were not arbitrary and capricious based on the record then before the agency says nothing about whether similar rules issued nearly 30 years later should be sustained. Indeed, HHS acknowledges that it

[5] Plaintiffs' amici underscore the agency's many failures in this regard. *See, e.g.*, Policy Integrity Amicus Br. 5 (HHS "ignor[ed] best practices and pluck[ed] from thin air its estimates of costs and benefits[.]"), Dkt. 63.

was obligated to engage in reasoned decisionmaking and consider the evidence before it to evaluate the wisdom of the policy "'on a continuing basis'" in light of current facts. Opp. 38. Blind reliance on *Rust* does not suffice.

1. The Gag Requirement's restrictions on pregnancy counseling are arbitrary and capricious

HHS failed to meaningfully consider numerous problems with the Gag Requirement, including that it directly contradicts the professional and ethical obligations of medical professionals. As a result, these health care providers will be forced to withdraw from the Title X program and public health will suffer. *See* Mot. 20-22.

HHS claims that it considered and responded to this core problem with the Final Rule. Opp. 44. In fact, HHS's consideration consisted of the simple statement that it "believes that the final rule adequately accommodates medical professionals and their ethical obligations while maintaining the integrity of the Title X program." 84 Fed. Reg. at 7,724; *see also* Opp. 44. HHS's "belie[f]" is insufficient. "Stating that a factor was considered … is not a substitute for considering it," and an agency must provide more than "conclusory statements" to prove it "considere[ed] [the relevant] priorities." *Getty v. Fed. Savs. & Loan Ins. Corp.*, 805 F.2d 1050, 1055, 1057 (D.C. Cir. 1986); *accord Beno v. Shalala*, 30 F.3d 1057, 1075 (9th Cir. 1994).

Numerous leading organizations of medical professionals—including the organizations responsible for the very ethical requirements at issue, like the AMA—explained that the Gag Requirement contravenes medical ethics. *See* AMA Comment 3; ACOG Comment 5; PPFA Comment 11; *see also, e.g.*, ACOG Amicus Br. 11, Dkt. 79. Thus, the administrative record overwhelmingly demonstrates that health care professionals *cannot* comply with *both* their ethical obligations and the Final Rule. HHS has "offered an explanation for its decision that runs counter to the evidence before" it, and is "so implausible that it could not be ascribed to a

difference in view or the product of agency expertise." *Motor Veh. Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

Moreover, because the Final Rule would require medical professionals to violate their ethical duties, vast swaths of Title X providers will be forced to drop out of the program. That will have dire consequences for Title X patients and the public health. *See* Mot. 43-44; *see also, e.g.*, Public Health Scholars Amicus Br. 18-22, Dkt. 70. Planned Parenthood in particular—which serves approximately 40% of all Title X patients—made clear that it will be forced to leave the Title X program if the Gag Requirement goes into effect. PPFA Comment 15-16. HHS says virtually nothing about how the Title X program would operate on May 3—when the Gag Requirement goes into effect and when, absent an injunction, a provider representing 40% of the Title X program (as well as others) would drop out. Indeed, the government avoids almost any mention of Planned Parenthood at all in its brief (*see, e.g.*, Opp. 2 ("the American Medical Association and several other organizations")), and brushes off any concern about patient care. *See* Opp. 47 (the prospect of providers leaving is "'purely speculative'" and HHS does "not anticipate that there will be a decrease in the overall number of facilities offering services").

HHS criticizes what it calls "departure threats" as impermissible "tactic[s]" that "amount[] to a request that this Court constrain the authority of HHS beyond the limits imposed by Congress." Opp. 46. Planned Parenthood's departure from the Title X program is no "tactic"; it is a reflection of the fact that Planned Parenthood cannot comply with a Rule that would force it to violate its ethical and professional responsibilities and that would harm patient care. And to this day, HHS has not explained how it could or would fill the void left behind. Nor did it even acknowledge that the nation's largest provider of Title X services will be forced to exit the program when it asserted that the Final Rule will result in "more clients being served,

gaps in service being closed, and improved client care." 84 Fed. Reg. at 7,723.

The government also ignores the risks to patient health from their inability to receive referrals for abortion. *See* Mot. 22-23. Patients who want to terminate a pregnancy will face delays as they are forced to search for information on their own or visit other providers to learn about how and where to obtain an abortion, resulting in increased risks of complications from abortion or continued pregnancy. HHS disavowed awareness 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." 84 Fed. Reg. at 7,775. But that data is in the administrative record—HHS just ignored it. *See, e.g.*, Brindis Comment Ltr. 6-7, 12 (July 31, 2018).

2. The Gag Requirement's speaker-based ban is arbitrary and capricious

The Gag Requirement's speaker-based prohibition on anyone but physicians and advanced practice providers ("APPs") providing pregnancy counseling was also not the product of reasoned decisionmaking—indeed, it was not mentioned in the proposed rule at all. *See* Mot. 25-28. Thus, not only was this ban promulgated without proper procedure, *see infra* p. 23, it is arbitrary and capricious because HHS "entirely failed to consider an important aspect of the problem." *State Farm*, 463 U.S. at 43.

HHS disregarded its own estimate that non-APPs "were involved with 1.7 million Title X family planning encounters in 2016," 84 Fed. Reg. at 7,778, as well as evidence demonstrating that these non-APPs are primary providers of patient education and counseling, *see* Office of Population Affairs, *Title X Family Planning Annual Report: 2017 National Summary*, at 4 (August 2018) ("*Title X Annual Report*"); Gardner Decl. ¶¶ 46-48, Dkt. 44; Madara Decl. ¶ 28, Dkt. 49. HHS failed to consider that, by prohibiting non-APPs from providing any pregnancy

counseling, pregnant patients will face delays and disruptions in care. HHS also asserts that, in promulgating this restriction, it "considered which types of health care professionals to [permit to provide pregnancy counseling], and reasonably drew the line at [APPs] who have 'advanced medical degrees, licensing, and certification requirements.'" Opp. 41. But HHS has never explained *why* such degrees or certification are necessary for providing nondirective pregnancy counseling. As Plaintiffs have detailed, they are not, and HHS's deficiency on this score is particularly glaring given that non-APPs currently provide pregnancy counseling in many instances. *See, e.g.*, Gardner Decl. ¶ 46; Custer Decl. ¶ 74, Dkt. 43; *see also* ACOG Amicus Br. 20-21, Dkt. 79.

3. The Separation Requirement is arbitrary and capricious

With regard to the Separation Requirement, the government again repeats the refrain that similar regulations were upheld in *Rust*. That provides the government no help. HHS must consider present circumstances and address the evidence before it.

a. The government makes much of the claim that the Final Rule addresses the "risk that Title X and other funds will be comingled" and that "Title X funds will be used for prohibited purposes." Opp. 32. It also touts that it purportedly provided empirical evidence in support of its restrictions (Opp. 33, 35); in particular, that HHS cited to a 2014 study by the Guttmacher Institute for the proposition that abortions are "increasingly performed 'at sites that focus primarily on contraceptive and family planning services,'" and apparently assumed this meant that abortions were increasingly being performed at Title X sites. 84 Fed. Reg. at 7,765; *see* Opp. 34. Even if that assumption were correct, HHS nowhere claims that Title X funds are being used to perform abortions. Indeed, it cites not one example of that ever happening over the past 50 years. There is no reasoned justification for physical separation requirements so extreme that they will result in the shuttering of Title X centers across the country. *See Michigan v. EPA*,

135 S. Ct. 2699, 2707-2708 (2015) ("reasonable regulation ordinarily requires paying attention to the advantages *and* the disadvantages of agency decisions"; "'too much wasteful expenditure devoted to one problem may well mean considerably fewer resources available to deal effectively with other (perhaps more serious) problems'").[6]

HHS also relies (Opp. 33) on commenters' claims that the Separation Requirement would "increase the cost of doing business" as demonstrating the necessity of the Separation Requirement, because if the "collocation of a Title X clinic with an abortion clinic permits the abortion clinic to achieve economies of scale, the Title X project (and, thus, Title X funds) would be supporting abortion as a method of family planning." 84 Fed. Reg. at 7,766. This argument gets the facts backwards. While Title X funding is vital to supporting providers' missions of providing reproductive health care to low-income individuals, Title X grants are typically not sufficient to support the continuing operation of a Title X health center. And there is no evidence that Title X funds are being used to provide abortion services, as HHS has repeatedly confirmed through audits.[7]

b. The government is incorrect in arguing it is not required to take into consideration the "reliance interests" engendered by the prior policy that HHS now seeks to change. *See* Opp. 37. The Supreme Court has explained that a when a prior policy has "engendered serious

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[6] The government argues that alleged examples of "overbilling in the Medicaid program … 'illustrate the need for clarity with respect to permissible and impermissible activities.'" Opp. 34. That claim is meritless. HHS admitted in the Final Rule that "demonstrated abuses of Medicaid funds do not necessarily mean Title X grants are being abused." 84 Fed. Reg. at 7,725.

[7] HHS cites in its brief one Planned Parenthood affiliate's declaration stating that one of the health centers that would have to close due to a loss of Title X funds also provides abortions, and the government claims that this "confirm[s] the legitimacy of the agency's concerns." Opp. 33. The fact that this health center would close says nothing in support of HHS's unsupported suggestion that Title X funding supports abortion services. The evidence shows the opposite. As that affiliate declared: "We are … subject to audits by HHS, and we have passed all of our audits." Black Decl. ¶ 36, Dkt. 51.

reliance interests," an agency must "provide a more detailed justification than what would suffice for a new policy created on a blank slate." *FCC v. Fox Tel. Stations, Inc.*, 556 U.S. 502, 515 (2009). Title X grantees have structured their organizations to comply with long-settled Title X regulations while maximizing the number of low-income patients seeking reproductive health care they can serve. A new requirement that will now force them to completely reorganize, acquire and upfit new facilities or engage in extensive renovations, hire duplicate staff, and create a second set of health and other administrative records—at a cost of millions of dollars—surely requires a more detailed justification than what HHS has provided.

HHS also claims that Title X grantees may not claim any reliance interests because Title X funding is discretionary and only lasts for one year. Opp. 37. That is wrong as a matter of law. *See Vidal v. Nielsen*, 279 F. Supp. 3d 401, 431 (E.D.N.Y. 2018) ("The record does not indicate that Defendants acknowledged, let alone considered, … reliance interests engendered by the DACA program. That alone is sufficient to render their supposedly discretionary decision to end the DACA program arbitrary and capricious."). In any event, Plaintiffs do not claim reliance on the *receipt* of Title X funding. They invoke reliance on regulations as to rights and obligations under the Title X program that have remained the same for nearly half a century.

c. The government's only response to Plaintiffs' argument that HHS drastically underestimated the costs of compliance is that the Rule "permits consideration of providers' particular circumstances." Opp. 48. That is no response. To begin with, providers will have to assume each of the "factors" identified by the Separation Requirement is mandatory, and would have to give each factor the broadest possible reading to make sure they do not run afoul of its provisions. *See, e.g.*, Custer Decl. ¶ 82. Moreover, whatever "consideration of … circumstances" is purportedly allowed, the administrative record demonstrates that HHS's

estimate that affected grantees will incur average costs of $30,000 to comply with the Separation Requirement, *see* 84 Fed. Reg. at 7,782, is less than one twentieth of the actual costs, *see* PPFA Comment 32. Agency action that fails to adequately consider the costs of a regulation cannot be sustained. *See, e.g.*, *Council of Parent Attorneys & Advocates, Inc. v. DeVos*, 2019 WL 1082162, at *13 (D.D.C. Mar. 7, 2019).

C. The Gag Requirement's Speaker-Based Ban Was Promulgated Without Proper Procedure

HHS now claims that the new speaker-based ban on who can provide "nondirective pregnancy counseling"—namely, only physicians or APPs—was actually a logical outgrowth of the proposed rule. But the cited portions of the proposed rule on which the government relies in its brief stated that a "physician" would be permitted to provide "nondirective counseling *on abortion*," 83 Fed. Reg. 25,502, 25,507, 25,518 (June 1, 2018) (emphasis added). Thus, as Plaintiffs explained (Mot. 26 n.6), this language at most vaguely suggested an exception to the proposed requirement that Title X projects could not provide counseling *on abortion*. 83 Fed. Reg. at 25,507 (emphasis added). There was no indication that HHS was proposing that only doctors (or some other subset of medical professionals) could provide nondirective *pregnancy* counseling—whether on abortion or otherwise. The government's assertion to the contrary (Opp. 51) misstates what it said in the proposed rule.

II. Plaintiffs Will Suffer Irreparable Harm Absent An Injunction

HHS attempts to dismiss Plaintiffs' evidence of irreparable harm. But what the government passes off as "speculative predictions" (Opp. 4) or a "chain of hypotheticals" (Opp. 59) is sure to become a reality for Plaintiffs, their affiliates and members, and—most important—their patients, the low-income individuals that Title X was designed to serve.

If the Final Rule goes into effect, Planned Parenthood will be compelled to leave the Title

X program. *See, e.g.*, Custer Decl. ¶ 6; Gardner Decl. ¶ 8; Udall Decl. ¶ 7, Dkt. 45. The Gag Requirement violates their ethical and professional responsibilities, *e.g.*, Custer Decl. ¶ 6; Ewing Decl. ¶ 6; Megregian Decl. ¶ 7; Madara Decl. ¶¶ 10-21; and the Separation Requirement is prohibitively expensive and harmful to patient care, *e.g.*, Custer Decl. ¶¶ 83, 89; Gardner Decl. ¶ 57, Udall Decl. ¶ 48.[8]

Thus, as a direct result of the Final Rule, Planned Parenthood member affiliates, including the plaintiff affiliates here, will lose funding, be forced to cut services, and will lose patients who will be forced to move on to other providers. Udall Decl. ¶¶ 51-53; Gardner Decl. ¶¶ 61-63. Some Planned Parenthood affiliates will be forced to lay off staff and close health centers entirely. Custer Decl. ¶¶ 110, 122-123. These harms cannot be reversed: Fired staff will move on, patients will be unwilling to return, and physical center space will be lost. *See* Custer Decl. ¶¶ 72, 110. Moreover, compliance with the Separation Requirement would, at minimum, be very costly and would divert finite resources away from providing health care. *See* Custer Decl. ¶ 87. These costs cannot be recovered if Plaintiffs prevail in this litigation. *See* 5 U.S.C. § 702; *see also Idaho v. Coeur d'Alene Tribe*, 794 F.3d 1039, 1046 (9th Cir. 2015) (affirming that economic harm was irreparable where sovereign immunity would prevent recovery of money damages).[9]

As Plaintiffs further detailed, the Gag Requirement will lead inevitably to an erosion of

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[8] The government states that a Title X project will "come out ahead" "if the costs of compliance are less than Title X funding" because they can "simply forgo receiving taxpayer funds." Opp. 57. That argument is backwards. The irreparable-injury inquiry looks to the harm caused by implementation of the Final Rule compared to the status quo.

[9] The government says that "'ordinary compliance costs are typically insufficient to constitute irreparable harm.'" Opp. 57. This misses the mark. Plaintiffs' point is not *only* that compliance will be expensive. Plaintiffs are irreparably harmed because diverting funds away from patient care to comply with the Final Rule will harm their ability to care for low-income patients—exactly those patients Title X is meant to serve. Mot. 40-41.

patient trust and will impair patients' ability to get the care of their own choosing. *See* Megregian Decl. ¶¶ 28-48; Ewing Decl. ¶¶ 29-51; Madara Decl. ¶¶ 15, 21. This is true for providers and patients around the country. In regions where affordable health care is scarce, if patients cannot turn to Title X providers, they will be left with few options or none at all and will either ration care or go without. Custer Decl. ¶ 92; Udall Decl. ¶ 53; Gardner Decl. ¶ 63. Moreover, when Plaintiffs and their members and affiliates cannot deliver the high-quality, nonjudgmental, and comprehensive reproductive care for which they are known—either because they are forced to withdraw from the program or stay in and provide ethically compromised care—Plaintiffs cannot carry out their mission. Custer Decl. ¶¶ 6, 71; Madara Decl. ¶¶ 22-24. Plaintiffs will also be irreparably harmed by the loss of patients and goodwill that would result if Planned Parenthood has to turn away patients because of closures, services reductions, or lack of funds. Custer Decl. ¶ 92.

The government does not dispute that Plaintiffs' mission and goodwill among patients will be harmed. It argues instead that these harms are neither irreparable nor imminent (Opp. 58-59), but the government is wrong. Plaintiffs' harms are very real and cannot be repaired. *See Stuhlbarg Int'l Sales Co., Inc. v. John D. Brush & Co., Inc.*, 240 F.3d 832, 841 (9th Cir. 2001) ("[e]vidence of threatened loss of … goodwill certainly supports a finding of the possibility of irreparable harm"); *see also Doe v. Trump*, 288 F. Supp. 3d 1045, 1082 (W.D. Wash. 2017). As for immediacy, as of May 3, the compelled violation of medical ethics will be immediate; the provision of incomplete and misleading information to pregnant women will be immediate; the dramatic restructuring of the Title X patient-provider relationship will be immediate.

The government also claims Plaintiffs cannot rely on the irreparable harm the Final Rule will cause their patients. Opp. 58-59. That is wrong. Courts in this circuit have found that harm

to a physician's or health care entity's patients is a cognizable harm sufficient to merit preliminary relief (even if it were not, those harms surely would factor into the Court's public interest analysis). *See Pacific Radiation Oncology, LLC v. Queen's Med. Ctr.*, 555 F. App'x 730, 732 (9th Cir. 2014) (affirming finding of irreparable harm for physician based on patients' loss of needed procedures; physician "would suffer irreparable harm to relationships with patients"); *Planned Parenthood Ariz., Inc. v. Betlach*, 899 F. Supp. 2d 868, 886 (D. Ariz. 2012) (inability to provide health care to patients is irreparable harm); *Sharp Healthcare v. Leavitt*, 2008 WL 962628, at *5 (S.D. Cal. Apr. 8, 2008) (irreparable harm where loss of Medicaid funding would force the plaintiffs' patients to find alternate care). The government's reliance (Opp. 58) on *Exeltis USA Inc. v. First Databank, Inc.*, 2017 WL 6539909, at *9 (N.D. Cal. Dec. 21, 2017), is misplaced. The court in *Exeltis* expressly distinguished the situation where a health care provider demonstrates harm to its patients. *See id.* at *9.

Finally, the government's assertion that the harms to the public health are hypothetical or not imminent is unsupported. Plaintiffs, by contrast, supported their claims with evidence in the administrative record, and supplemented that evidence with the expert and fact declarations submitted in this case. *See* Mot. 43-44. There is nothing "speculative" about the harms Plaintiffs invoke. *E.g.*, Brindis Decl. ¶ 47, Dkt. 52. These harms are rooted in prior experiences with state-administered programs placing restrictions on family-planning services, with significant adverse public health consequences. *See id.* (describing negative public health consequences in Texas); Kost Decl. ¶¶ 119-122 (restrictive policies in Texas and Iowa "resulted in widespread disruption of their programs' provider networks, leading to diminished access to

contraceptive services and ongoing difficulty for individuals finding alternative providers").[10]

III. The Balance Of Equities And Public Interest Favor An Injunction

The balance of equities and public interest strongly weigh in favor of a preliminary injunction. The Final Rule would dramatically reshape the Title X program that has operated under regulations substantially similar to those currently in effect for nearly half a century, push some of the largest Title X providers out of the program, and leave patients with reduced access—or no access at all—to the doctors, nurses, and staff who meet their critical health care needs. *See* Mot. 23, 42. These interests easily outweigh any abstract injury the government asserts is caused by the failure to enforce their new regulations. *See* Opp. 59.

In arguing the equities, the government also errs in asserting that the "likely" remedy if Plaintiffs prevail is a remand without vacatur. Opp. 60. "[R]emand without vacatur" is the exception—ordered only in "limited circumstances." *Pollinator Stewardship Council v. EPA*, 806 F.3d 520, 532 (9th Cir. 2015). Courts order remand without vacatur only "when equity demands," *id.*, or to prevent extraordinary harm, *e.g.*, *California Communities Against Toxics v. EPA*, 688 F.3d 989, 994 (9th Cir. 2012). This is not such a case. The government seeks to radically restructure the Title X program, in the face of overwhelming evidence that the Final Rule will harm patients and providers.

IV. The Final Rule Should Be Enjoined In Its Entirety

HHS argues that any injunctive relief should be "[l]imited [t]o [t]he Plaintiffs." Opp. 61.

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[10] On March 29, 2019, after Plaintiffs filed their opening brief, the Office of Population Affairs released Title X service grants for fiscal year 2019. *See* HHS, Office of Population Affairs, *Recent Grant Awards* (2019). As explained in the supplemental declaration of Kimberly Custer, seven Planned Parenthood affiliates were awarded direct grants, but four Planned Parenthood affiliates were denied. Custer Supp. Decl. ¶¶ 4, 6 (Apr. 18, 2019). HHS does not invoke these recent Title X awards to argue against irreparable harm, nor could it since Planned Parenthood's affiliates continue to serve more than 1,500,000 Title X patients across the country.

HHS then invokes severability, and argues that an injunction should be limited to the provision or provisions that the Court finds unlawful. Opp. 65. Both arguments fail.

A. HHS goes on at length about the purported impropriety of nationwide injunctions. *See* Opp. 61-65. But HHS otherwise acknowledges that that an injunction should "'provide[s] complete relief to the plaintiffs.'" Opp. 61. Therefore, at minimum, an injunction applying to each of the Plaintiffs, as well as their members and affiliates, is necessary to "provide complete relief" to Plaintiffs and "prevent the … harm extensively detailed in the record." *California v. Azar*, 911 F.3d 558, 584 (9th Cir. 2018). But HHS further does not dispute that AMA members practice in all States, and that Planned Parenthood operates 600-plus health centers in 48 States and the District of Columbia. *See* Mot. 44. Nor does it dispute that Planned Parenthood health centers alone serve approximately 40% of patients enrolled in Title X. Nor does it dispute that Planned Parenthood and AMA members work within both Title X direct grantees and delegate agencies. It is simply impossible to imagine how to provide complete relief in these circumstances, and HHS does not explain how the Court would, other than a nationwide injunction. *See, e.g.*, *Regents of the Univ. of Cal. v. U.S. Dep't of Homeland Sec.*, 908 F.3d 476, 512 (9th Cir. 2018) (granting nationwide injunction and faulting government for "fail[ing] to explain how the district court could have crafted a narrower injunction that would provide complete relief to the plaintiffs, including the entity plaintiffs").

B. HHS should be preliminarily enjoined from implementing the Final Rule in its entirety. A court "will sever and affirm a portion of an administrative regulation only when [it] can say without any substantial doubt that the agency would have adopted the severed portion on its own." *American Petroleum Inst. v. EPA*, 862 F.3d 50, 71 (D.C. Cir. 2017) (internal quotation marks and alterations omitted), *modified on rehearing*, 883 F.3d 918 (D.C. Cir. 2018). Even

where an agency has stated its intent that a regulation be severable, a court must ensure that "the balance of the rule can function independently if shorn of its [unlawful] aspects." *MD/DC/DE Broadcasters Ass'n v. FCC*, 236 F.3d 13, 22 (D.C. Cir. 2001). In other words, "'a severability clause is an aid merely; not an inexorable command.'" *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2319 (2016) (refusing to sever state statute notwithstanding severability clause).

The provisions Plaintiffs challenge here are the core of the Final Rule—the Gag Requirement and the Separation Requirement. They both span multiple sections and subsections, and they cannot be excised from each other, or from the rest of the rule, without distorting its purpose or at least rendering central parts unclear or unworkable. To this point, HHS simply states, without explanation or citation: "The separation requirements can function without the referral provisions and vice versa." Opp. 65. That is wrong.

First, the Gag Requirement alone informs the meaning of nearly every provision of the Final Rule. HHS has defined the term "family planning" to reflect the agency's dramatic restructuring of the Title X program to direct pregnant women away from abortion and toward continuing a pregnancy to term. As HHS states: "[T]he Department considers it appropriate to define 'family planning' as … permitting the provision of nondirective pregnancy counseling (including abortion and adoption), and … including and requiring Title X projects to refer for prenatal care services." 84 Fed. Reg. at 7,730. Because the term "family planning" is referenced throughout the Final Rule, there is substantial doubt if or how the agency would have adopted any of the rest of the rule.[11]

[11] *See, e.g.*, *id.* at 7,787 (to be codified at § 59.5(a)(1)) (requiring Title X project to "[p]rovide a broad range of acceptable and effective *family planning* methods") (emphasis added); *id.* at 7,787 (to be codified at § 59.5(a)(14)) (requiring Title X project to "[e]ncourage family participation in the decision to seek *family planning* services") (emphasis added); *id.* at

Second, as Plaintiffs previously explained and HHS ignores, the Gag and Separation Requirements are expressly integrated. *See, e.g.*, Mot. 13. In particular, under the Final Rule, Title X projects must physically and financially separate their Title X activities from so-called "prohibited activities." 84 Fed. Reg. at 7,789. The "prohibited activities" are defined by cross-reference to other sections of the rule—including the Gag Requirement. *Id*. Thus, if, for example, the Gag Requirement were held unlawful, then the so-called "prohibited activities" would, at least in part, no longer be prohibited. In turn, the Separation Requirement necessarily would need to be altered too—strictly speaking, line edited. Especially given HHS's cursory, unsupported argument, the Court should reject its severability request out of hand. *See Texas v. EPA*, 829 F.3d 405, 435 (5th Cir. 2016) (staying regulation "in its entirety" because agency "offer[ed] nothing beyond … cursory comment").

The Final Rule must be vacated in its entirety. *See MD/DC/DE Broadcasters Ass'n*, 236 F.3d at 23 (vacating entire rule notwithstanding severability clause).

CONCLUSION

The Final Rule is contrary to federal law and arbitrary and capricious, and was promulgated without proper procedure. Plaintiffs' motion for a preliminary injunction should be granted. In the alternative, if the Court were to deny Plaintiffs' motion, Plaintiffs respectfully request (1) that the Court stay the Final Rule pending appeal under Federal Rule of Appellate Procedure 8; or (2) grant a temporary administrative stay while Plaintiffs seek emergency relief from the Ninth Circuit.

7,788 (to be codified at § 59.7(c)(1)) (determining eligibility based on "[t]he degree to which the applicant's project plan adheres to the Title X statutory purpose and goals for the establishment and operation of voluntary *family planning* projects") (emphasis added).

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Respectfully submitted,

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