UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MAINE

THE FAMILY PLANNING ASSOCIATION OF MAINE D/B/A MAINE FAMILY PLANNING, on behalf of itself, its staff, and its patients;

and

J. DOE, DO, MPH, individually and on behalf of Dr. Doe's patients,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES;

ALEX M. AZAR II, in his official capacity as Secretary of Health and Human Services;

OFFICE OF POPULATION AFFAIRS;

and

DIANE FOLEY, M.D., in her official capacity as the Deputy Assistant Secretary for Population Affairs,

Defendants.

Case No. 1:19-cv-00100-LEW

MEMORANDUM IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION

INJUNCTIVE RELIEF SOUGHT

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Maine Family Planning ("MFP") and Dr. J. Doe (collectively "Plaintiffs") seek a preliminary injunction of Defendants' unlawful changes to the Title X family planning program ("the Rule"). When the Rule begins to take effect on May 3, 2019, it will upend decades-old policies grounded in evidence-based health care standards and core medical ethics, wreaking havoc on family planning and other health care. The Rule has been opposed by nearly every leading medical association and public health policy organization in the country.

Two components of the Rule, in particular, will irreparably harm Plaintiffs and their patients: (1) the "Gag Rule," which, *inter alia*, prohibits health professionals from providing their patients with abortion referral information—even if patients directly request it—while simultaneously mandating that each patient be referred for prenatal services, regardless of whether such a referral is wanted or appropriate; and (2) the "Separation Requirement," which requires that all abortion services be physically separated from clinics that also provide Title X services, notwithstanding the fact that Title X funds *are not now and never have been* used to provide abortion at those sites. This requirement specifically targets Title X providers, like MFP, that have been providing family planning services and abortion at the same locations for decades in reliance on the longstanding program policies and rules. MFP has been the sole Title X grantee in the state of Maine for the last 48 years, during which time no government or independent auditor has ever found MFP in violation of any of the Title X requirements.

If these provisions go into effect, providers like MFP will face an impossible dilemma—either substantially curtail their services or leave the Title X program altogether and lose crucial funding. If MFP implements the Rule, Maine will suffer an 85% decrease in abortion clinics. But if MFP is forced to leave the Title X program, it will have to close more than half of its clinics entirely, causing thousands of women in Maine to lose access to *both* family planning

services and abortion services. The Rule will push high-quality medical providers out of the Title X program because it will be impossible for them to meet the onerous new requirements, and there is no evidence that replacement providers exist or will be able to comply with the Rule. Women across the country will thus lose access to subsidized family planning services and, for many, to their sole health care provider. In short, the Rule threatens to destroy the Title X program, undoing one of the great public health achievements of the twentieth century.

In promulgating the Rule, Defendants brushed aside overwhelming evidence of its negative impacts, citing only concerns about *possible* confusion or *hypothetical* commingling of resources. Defendants, instead, rely on *Rust v. Sullivan*, 500 U.S. 173 (1991)—a case that addressed a similar rule from over thirty years ago that never fully went into effect—in lieu of providing any evidence or assessment of the facts and law in place *today*. In so doing, Defendants fail to acknowledge, much less consider, the numerous material changes that have occurred in the thirty years since *Rust*: new legislation that clarifies Congress's intent and bars precisely this type of regulation; new standards for Fifth and First Amendment challenges that render the Rule unconstitutional; and a new factual landscape generated in reliance on the longstanding regulations. *Rust*, therefore, does not control the Rule's legality.

Indeed, the Rule is unlawful for multiple reasons. First, it violates the Administrative Procedure Act ("APA"): it violates controlling statutes that have been enacted since *Rust* was decided, including the Affordable Care Act. It is contrary to Congress's intent, as made clear by the Congressional response to *Rust*. And it is arbitrary and capricious because Defendants fail to provide reasoned analysis based on the *current* state of the Title X program and *current* medical ethics and standards of care, while at the same time ignoring the acute reliance interests of the Title X provider network on the government's now decades-old policy.

Second, the Rule violates Plaintiffs' patients' fundamental right to choose abortion before viability. The Rule will lead to large-scale clinic closures, forcing patients in Maine to travel great distances for abortion services and delaying care or preventing it altogether.

Third, the Rule violates MFP's First Amendment right to freedom of speech by imposing content- and viewpoint-based government control over the speech of medical professionals. The Supreme Court held just last year that regulating the content of medical professionals' speech "poses the inherent risk that the Government seeks not to advance a legitimate regulatory goal, but to suppress unpopular ideas or information." *Nat'l Inst. of Family & Life Advocates* ("*NIFLA*") *v. Becerra*, 138 S. Ct. 2361, 2374 (2018). The Rule likewise imposes an unconstitutional condition on MFP's receipt of Title X funds.

Finally, the Rule is unconstitutionally vague. The Rule provides so little guidance that, if it goes into effect on May 3, providers will be unable to reasonably implement the Rule and will be vulnerable to arbitrary enforcement.

A preliminary injunction is warranted given the irreparable harms this Rule will inflict. An injunction will prevent immediate, drastic alteration to the Title X provider network and the violation of Plaintiffs' constitutional rights by simply preserving the status quo that has been in place for decades. Accordingly, Plaintiffs' motion should be granted.

BACKGROUND

I. Maine Family Planning

MFP has been the sole federal Title X grant recipient in Maine since 1972. Ex. 1, Declaration of George Hill ("Hill Decl.") ¶ 5. It provides family planning services to approximately 24,000 Mainers annually through a 47-site network headquartered in Augusta and

spanning 15 counties, including 18 clinics that it directly controls and operates.[1] *Id.* ¶¶ 10, 14. 78% of MFP's patients have incomes under 250% of the federal poverty line and so qualify for free or reduced fee services; 31% of its family planning patients were uninsured in 2017. *Id.* ¶¶ 14, 24. MFP offers through its family planning program annual gynecological exams, counseling, contraception, and cancer and sexually transmitted infection screenings, among other services. Ex. 2, Declaration of Evelyn Kieltyka ("Kieltyka Decl.") ¶ 6. To support these services, in FY 2018 MFP received Title X grant funding of $1,929,655, which constituted 39% of its family planning funding and 27% of its overall budget. Hill Decl. ¶ 15.

MFP has also since 1997 provided first-trimester abortion at its clinic in Augusta. Hill Decl. ¶ 7. Over that time, abortion has been funded privately and kept financially separate from Title X programs. Hill Decl. ¶¶ 7-8, 17. Medication and aspiration abortions are provided by physicians one day a week, a day on which no Title X activities take place. Kieltyka Decl. ¶ 18. More recently, MFP has been able to offer medication abortion at its 17 other directly controlled clinics via telemedicine. *Id.* ¶ 19. In total, MFP provides approximately 500 abortions a year, of which approximately 25% are provided outside of the Augusta clinic. *Id.* ¶ 20. Besides MFP, the only other places in Maine where medication and aspiration abortion services are publicly available (i.e., generally open to new patients) are: (1) Planned Parenthood of Northern New England ("PPNNE") in Portland; and (2) the Mabel Wadsworth Center in Bangor. *Id.* ¶ 21. Each of these sites generally provides abortion only one day a week. *Id.*

[1] MFP's network includes: eighteen directly operated sites (located in Augusta, Bangor, Belfast, Calais, Damariscotta, Dexter, Ellsworth, Farmington, Fort Kent, Houlton, Lewiston, Machias, Norway, Presque Isle, Rockland, Rumford, Skowhegan and Waterville); four sites managed by Planned Parenthood of Northern New England ("PPNNE") (in Portland, Sanford, Topsham, Biddeford); four federally qualified health centers ("FQHCs") with 20 clinic sites in total (six of which are located in Portland, and others are in Belgrade, Bethel, Bingham, Lovejoy, Madison, Mt. Abram, Rangeley, Sheepscot, Strong, Waterville, Vinalhaven); and five school-based health centers (three in Portland, and one in Readfield, and one in Calais). Hill Decl. ¶ 10.

MFP has never been found in violation of any Title X requirements, either by government auditors or by its own internal oversight. Hill Decl. ¶¶ 16-22.

II. Title X

Congress created Title X, the only federal program specifically dedicated to funding family planning services, in 1970. Public Health Service Act, 84 Statute 1506, as amended 42 U.S.C. §§ 300 to 300a-6. Unlike fee-for-service programs like Medicaid, Title X grant money is provided in a lump sum and 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. Title X funds may not be used to pay for abortion services. *Id.* § 300a-6.

Title X is a competitive grant program, meaning that eligible entities must apply to the Office of Population Affairs ("OPA") in the Department of Health and Human Services ("HHS") to be awarded funds. 42 C.F.R. §§ 59.3-4. There are currently 3,858 sites across the country serving over four million patients. Ex. 3, Declaration of Martha J. Bailey ("Bailey Decl.") ¶¶ 27-28.[2] Site operators include government health departments, hospitals, Planned Parenthood health centers, federally qualified health centers ("FQHCs"), and other private non-profit organizations like MFP. For over 60% of Title X patients, Title X providers are their only regular or usual source of health care and health education. *Id.* ¶ 27.

Title X-funded clinics provide high-quality family planning care that women prefer over other health care outlets. Title X-funded sites offer more effective types of contraception and better contraceptive counseling than other health centers or publicly-funded clinics; provide a

[2] Dr. Martha Bailey, a Professor of Economics at the University of Michigan and member of the executive boards of the American Economics Association and Executive Board of the Society of Labor Economists, has conducted extensive research on the historical, economic, and social impact that family planning services have had on American society. Bailey Decl. ¶¶ 1, 3, 10.

greater variety of services on site; and have better same-day and walk-in appointment availability. *Id.* ¶¶ 36-45. One study estimated that in 2015 the contraceptive care delivered by Title X-funded clinics helped avoid 822,300 unintended pregnancies, which would have resulted in 387,000 unplanned births and 278,000 abortions. *Id.* ¶ 52.

With only one brief and controversial exception thirty years ago, the regulations governing Title X have always allowed Title X projects to share facilities with abortion providers and have consistently required Title X providers to offer "nondirective" options counseling to pregnant women and referrals for abortion services upon request. *See* Standards of Compliance for Abortion-Related Services in Family Planning Services Projects, 65 Fed. Reg. 41270, 41272-73 (July 3, 2000) (formalizing these requirements). "Nondirective counseling" is commonly understood in medicine to mean patient-directed counseling that presents neutral and unbiased information regarding all options relevant to the patient and consistent with the patient's expressed wishes to hear the information, including in the context of pregnancy, prenatal care, adoption, and/or abortion. Ex. 4, Declaration of Matthew Wynia ("Wynia Decl.") ¶ 13.[3]

In 1988, HHS issued a rule ("the 1988 Rule") that prohibited Title X recipients who refer for or counsel on abortion care from receiving federal family planning funds, and required physical and financial separation of Title X services from abortion services and ancillary abortion-connected services. Statutory Prohibition on Use of Appropriated Funds In Programs Where Abortion Is a Method of Family Planning; Standard of Compliance for Family Planning Services Projects, 53 Fed. Reg. 2922 (Feb. 2, 1988). The 1988 Rule was initially enjoined, but

[3] Dr. Matthew Wynia, Director of the Center for Bioethics and Humanities at the University of Colorado, directed the American Medical Association's Institute for Ethics from 2000-2013, has held many other positions focused on medical ethics, and has published more than 150 peer-reviewed journals on medical ethics. Wynia Decl. ¶¶ 1-10.

the United States Supreme Court, in *Rust v. Sullivan*, 500 U.S. 173 (1991), ultimately held that it was facially lawful. The 1988 Rule never went into full effect before being suspended in 1993.

Prior to its suspension and in response to the 1988 Rule, in September 1992 Congress passed a bill that explicitly allowed abortion counseling within Title X. Family Planning Amendments Act of 1992, S. 323, 102nd Cong. (1992) ("FPAA"). The FPAA would have required counseling and referral on all pregnancy options, including abortion. *See* 138 Cong. Rec. 9862 (1992). After then-President Bush vetoed the bill, Congress responded by including similar language in its appropriations bill for Title X, which has been included every year since 1996, requiring that "all pregnancy counseling shall be nondirective" (the Nondirective Counseling Mandate) alongside the statement that "amounts provided to [Title X] projects . . . shall not be expended for abortions." *See, e.g.*, Continuing Appropriations Act, 2019, Pub. L. 115–245, 132 Stat. 2981, 3070–71 (2018).

Additionally, in 2010, Congress passed Section 1554 of the Patient Protection and Affordable Care Act ("ACA"), 42 U.S.C. § 18114 (2012), which reads:

> Notwithstanding any other provision of this Act, the Secretary of Health and Human Services 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.

III. HHS's New Rule

On May 22, 2018, HHS released a notice of proposed rulemaking ("Proposed Rule"), reversing its longstanding policy and largely reinstating the 1988 Rule, including provisions that

severely limited and in many circumstances banned Title X recipients from providing their patients with necessary referral and counseling for abortion services, and provisions that required strict physical separation between abortion services and Title X services. Compliance With Statutory Program Integrity Requirements, 83 Fed. Reg. 25,502 (proposed June 1, 2018). Among many other organizations opposing the Proposed Rule, most major medical associations—including the American Medical Association, the American College of Obstetricians and Gynecologists, the American College of Physicians, the American Academy of Family Physicians, the American Academy of Nursing, and the American Academy of Pediatrics—submitted comments in opposition.[4] Nonetheless, HHS published the final regulations in largely identical form ("the Rule"). Compliance With Statutory Program Integrity Requirements, 84 Fed. Reg. 7714 (Mar. 4, 2019) (to be codified at 42 C.F.R. pt. 59).

Most of the Rule, including its Gag provisions, goes into effect on May 3, 2019. Compliance with the physical separation requirements is required by March 4, 2020. *Id.* at 7714.

A. Gag Rule

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." *Id.* at 7788-89. No information about abortion providers, identified as such, may be provided to a patient. At the same time, Title X providers must provide all

[4] Letter from James L. Madara, CEO & Exec. Vice President, Am. Med. Ass'n, to Alex Azar, Sec'y, U.S. Dep't of Health & Human Servs. (July 31, 2018) [hereinafter AMA Letter]; Letter from Lisa M. Hollier, President, Am. Coll. of Obstetricians & Gynecologists, to Alex Azar, Sec'y , U.S. Dep't of Health & Human Servs. (July 31, 2018) [hereinafter ACOG Letter]; Letter from Ana María López, President, Am. Coll. of Physicians, to Alex Azar, Sec'y , U.S. Dep't of Health & Human Servs. (July 31, 2018) [hereinafter ACP Letter]; Letter from John Meigs, Jr., Bd. Chair, Am. Acad. of Family Physicians, to Alex Azar, Sec'y, U.S. Dep't of Health & Human Servs. (July 25, 2018) [hereinafter AAFP Letter]; Letter from Karen S. Cox, President, Am. Acad. of Nursing, to Alex Azar, Sec'y, U.S. Dep't of Health & Human Servs. (July 26, 2018) [hereinafter AAN Letter]; Letter from Colleen A. Kraft, President, Am. Acad. of Pediatrics, and Deborah Christie, President, Soc'y for Adol. Health & Med., to Alex Azar, Sec'y, U.S. Dep't of Health & Human Servs. (July 31, 2018) [hereinafter AAP Letter]. Hyperlinks to comments are available in the Table of Authorities, *supra*.

pregnant patients with a referral to prenatal services, regardless of the patients' wishes, on the grounds that prenatal referrals are "medically necessary." *Id.* at 7728, 7789. The provider may also provide the patient a list of "comprehensive primary health care providers," and "some, but not the majority" of the providers on the list may, though are not required to, be providers that "also provide abortion as part of their comprehensive services." *Id.* at 7789. The list may not include abortion providers who do not provide primary care, even if they are the only abortion providers in the area. And, even if a patient asks directly, Title X providers *may not* tell the patient which, if any, abortion providers are on the list, because the list "cannot be used to indirectly refer for abortion or to identify abortion providers to a client." *Id.* at 7761; *id.* at 7789.

The Rule states that physicians and narrowly-defined "advanced practice providers" ("APPs") may provide what it asserts to be "nondirective pregnancy counseling," yet requires that counseling be performed in a way that is entirely directive. *Id.* at 7787, 7789. Under the Rule, physicians and APPs must give patients information about carrying the pregnancy to term in conjunction with any information about abortion, even if the patient has already stated that she has decided to have an abortion. *Id*. at 7747 ("[A]bortion must not be the only option presented by physicians or APPs"). Meanwhile, medical providers that fall outside the Rule's narrow definition of APP are entirely prohibited from speaking the word "abortion." The Rule goes even further by preventing Title X clinics from making available to their patients *any* materials, written, video, web-based or otherwise, that so much as mention abortion, *even if no Title X funds are involved in providing the materials*. *Id.* at 7790.

B. Separation Requirement

The Rule requires that Title X activities be "physically and financially separate" (defined as having an "objective integrity and independence") from prohibited activities including the

provision of abortion services. *Id.* at 7789. 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 MFP, "might require more circumstances to be taken into account in order to satisfy a clear separation between Title X services and abortion services" 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.

IV. The Rule's Effects

Like other Title X grantees around the country, MFP will have to choose whether to implement the Rule and its onerous conditions, or else leave the program. Either choice will drastically affect the services Plaintiffs are able to offer their patients.

A. Continuing as a Grantee

To implement the Rule, MFP would need to stop providing abortion, abortion referral, and nondirective pregnancy options counseling at all of its own sites and subrecipient sites.

The separation requirement will force MFP to stop abortion-related activities at 17 of the 18 sites that currently offer those services. These sites are sufficiently small such that "separating" the sites will mean acquiring a separate building, rather than simply subdividing the space, and the cost of finding, building, and maintaining an additional 17 separate spaces is

prohibitive. Hill Decl. ¶¶ 30-38. When MFP stops providing abortion at these 17 sites, women across Maine seeking to access abortion will be forced to travel significantly farther for that care: in the northwest part of the state, most women will have to travel an additional 25-50 miles, while in the southeast, they will have to travel an additional 75 miles. Ex. 5, Declaration of Jason Lindo, Ph.D. ("Lindo Decl.") at ¶¶ 11-12.[5] While currently only 6.1% of MFP's satellite clinic patients have had to travel more than 25 miles to reach their nearest abortion provider, if MFP's satellites close, 82.7% of those patients would have to travel more than 25 miles to reach their nearest clinic to have an abortion, and 15.1% of patients would have to travel 100 miles or more. *Id.* ¶¶ 14-17. The effect of this increase in distance will be a decrease in abortions of around 11-13%. *Id.* ¶ 36; *see also* Ex. 6, Declaration of Julie Jenkins ("Jenkins Decl.") ¶¶ 23-26 (describing likely effects of increased travel burden on MFP patients' ability to obtain abortion); Declaration of Nurse Practitioner ("NP Decl.") ¶¶ 22-24, ECF No. 15-1 (Mar. 25, 2019) (same).

Even if MFP is able to separate its abortion services and its Title X services at its Augusta headquarters, doing so would come at a price much higher than the Rule's estimated costs of $20,000 to $40,000. MFP estimates that the Augusta building would, with an 800 square foot addition, accommodate separate family planning and abortion facilities with separate entrances. The physical alterations to the space alone would cost, at a minimum, $120,000-$135,000. Hill Decl. ¶¶ 40-42. If completely separate buildings are required, renting new clinical space to provide abortion services would cost over $200,000 with much of that cost recurring every four years. Building new space would cost between $250,000 and $400,000

[5] Dr. Jason M. Lindo is Professor of Economics at Texas A&M University, where he teaches courses on quantitative methods that economists use to evaluate the causal effects of government programs and other interventions. Dr. Lindo also has been employed at the National Bureau of Economic Research since 2011 and has published extensively in the research areas of health economics, public economics, and policy evaluation. Lindo Decl. ¶¶ 1-6.

without accounting for the price of land or cost of furnishing. *Id.* ¶ 43. MFP does not have funds in its annual operating budget to cover this type of one-time expense and would not be able to accomplish it within the Rule's specified one-year period. *Id.* ¶¶ 43-44.

Additionally, the Rule's prohibition on providing abortion referrals will prevent MFP's patients from obtaining relevant and timely information about their abortion options and hamper their ability to find a provider. Many non-Title X health care professionals, particularly in socially conservative regions of Maine, are reluctant to discuss all options available to women who are pregnant such that visiting another doctor would not necessarily provide the patient with the information she seeks. Some patients do not have readily available access to the Internet, which in any event is rife with misleading and medically inaccurate information about abortion. And many patients do not know what options would be appropriate for them—for example, whether medication abortion is a feasible option for their medical condition and location—and may assume that options not discussed by their Title X provider are not relevant or available. *See* NP Decl. ¶¶ 16, 19; Jenkins Decl. ¶¶ 13-14, 16. Refusing to provide complete, nondirective counseling will also damage the relationship of trust between MFP's health care professionals and their pregnant patients, compromise patient care, and require professionals to violate their ethical obligations. NP Decl. ¶¶ 17-19; Jenkins Decl. ¶¶ 17-21.

Finally, MFP expects that its subrecipient PPNNE will leave the Title X program even if MFP continues as a grantee. PPNNE's four sites handle over 40% of the patients seen by MFP's overall network, and MFP has not identified a replacement. Hill Decl. ¶ 56.

B. Leaving the Title X Program

If MFP instead leaves the Title X program, it will lose 39% of its current annual funding for family planning services. In the absence of a permanent alternative source of funding, MFP will need to close between 11 and 15 of its directly-controlled sites, including many of the most

rural. *Id*. ¶¶ 26-27. How many sites close depends on whether MFP also terminates its contracts with subrecipients; without those contracts, subrecipient family planning services would likely become more limited. *Id.* In total, absent the Title X program MFP would likely serve between 4,500 and 8,000 fewer family planning patients per year and would run a large and significant deficit. *Id.* ¶ 26. Closing these rural clinic sites would dramatically increase the travel distances required to access abortion and family planning. Lindo Decl. ¶¶ 18-19. Closing these sites would also reduce Maine women's access to high quality family planning services; an increase in travel distance to the nearest provider decreases the utilization of important reproductive health care, with the largest effect seen in women with less education. Bailey Decl. ¶¶ 90-93.

C. Nationwide Effects

Title X grantees across the country will face the same dilemma as MFP: HHS estimates that between 10% and 30% of sites currently co-locate Title X services and abortion services. 84 Fed. Reg. at 7781. Planned Parenthood, which provides care to over 40% of Title X patients, has already asserted that it will leave the program. Bailey Decl. ¶ 87. There is a substantial body of evidence demonstrating that the Rule will decrease the number of family planning clinics overall, increase wait times, and decrease the use of effective contraceptive methods. *Id.* ¶¶ 64-78. Additional evidence indicates that new family planning providers, whether those are FQHCs or faith-based organizations, will not be able to replace Title X providers who exit the program in either quantity or quality of needed services. *Id.* ¶¶ 86-93.

LEGAL STANDARD

"[T]rial courts have wide discretion in making judgments regarding the appropriateness of [preliminary injunctive] relief." *Baber v. Dunlap*, 349 F. Supp. 3d 68, 75 (D. Me. 2018) (citing *Francisco Sánchez v. Esso Standard Oil Co.*, 572 F.3d 1, 14 (1st Cir. 2009)). When making such judgments, courts weigh four factors:

> (1) the likelihood of success on the merits; (2) the potential for irreparable harm [to the movant] if the injunction is denied; (3) the balance of relevant impositions, i.e., the hardship to the nonmovant if enjoined as contrasted with the hardship to the movant if no injunction issues; and (4) the effect (if any) of the court's ruling on the public interest.

Esso Standard Oil Co. v. Monroig-Zayas, 445 F.3d 13, 17-18 (1st Cir. 2006) (quoting *Bl(a)ck Tea Soc'y v. City of Boston*, 378 F.3d 8, 11 (1st Cir. 2004). The claims and harms at issue in this case are properly addressed through a preliminary injunction.[6]

ARGUMENT

I. PLAINTIFFS' CLAIMS ARE LIKELY TO SUCCEED ON THE MERITS

A. The Rule Is Not in Accordance with Law

The APA requires courts to "hold unlawful and set aside agency action" that is "not in accordance with law." 5 U.S.C. § 706(2). Here, not only is the Rule inconsistent with Title X itself and the U.S. Constitution, *see infra* Parts I.B, C, but it also directly violates two federal statutes enacted after *Rust*: (1) the Nondirective Counseling Mandate, part of the Title X appropriations bill every year since 1996; and (2) Section 1554 of the ACA, passed in 2010.

1. The Gag Rule Violates Congress's Nondirective Counseling Mandate

Congress's Nondirective Counseling Mandate requires that "all pregnancy counseling shall be nondirective," which means that Title X patients must be presented with information about all of their options in pregnancy, consistent with the patient's desire to hear that information. Continuing Appropriations Act, 2019, 132 Stat. at 3070-71; Wynia Decl. ¶ 13; *see*

[6] *See, e.g.*, *Jackson Women's Health Org. v. Currier*, 760 F.3d 448 (5th Cir. 2014) (affirming preliminary injunction against law creating an undue burden on abortion access); *Women's Med. Ctr. of Nw. Houston v. Bell*, 248 F.3d 411, 422-23 (5th Cir. 2001) (affirming preliminary injunction of three regulations found to be unconstitutionally vague); *Franciscan All., Inc. v. Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016) (granting preliminary injunction of HHS regulations found contrary to law); *Wollschlaeger v. Farmer*, 814 F. Supp. 2d 1367, 1384 (S.D. Fla. 2011), *aff'd in relevant part sub nom Wollschlaeger v. Governor, Fla.*, 848 F.3d 1293 (11th Cir. 2017) (granting preliminary injunction of law restricting physicians' free speech rights).

also 42 U.S.C. § 300a-5 (requiring acceptance of Title X information to be strictly "voluntary"). Although the Rule purports to implement this requirement by giving "permission for nondirective pregnancy counseling," 84 Fed. Reg. at 7725, the terms of the Rule actually mandate *directive* counseling in several respects. First, the Rule imposes one-sided restrictions that drive patients away from choosing abortion: it prohibits referrals for abortion but requires referrals for prenatal care. Second, the Rule provides that medical professionals may furnish information about abortion only in conjunction with information about prenatal care or adoption while "[i]nformation about maintaining the health of the mother and unborn child" may be furnished alone. *Id.* at 7789. Nondirective counseling is by definition neutral, unbiased, and patient-directed. Wynia Decl. ¶ 13. Mandating that medical professionals provide information and referrals that the patient neither wants nor needs, while forcing them to withhold information about the option a patient does want, is none of those things.[7] The end result of these provisions is to impede patients, including those who receive care at MFP, from accessing abortion. *See* Jenkins Decl. ¶¶ 13-14; NP Decl. ¶¶ 15-16. In short, the Rule's purported "non-directive counseling" allowance is "nondirective" in name only.[8]

2. The Rule Violates Section 1554 of the ACA

The Rule also is unlawful and must be set aside because its Gag Rule and Separation Requirement violate *every prong* of Section 1554 of the ACA. 42 U.S.C. § 18114.

[7] As HHS's 2000 regulations explained, "requiring a referral for prenatal care . . . where the client rejected th[at] option[] would seem coercive and inconsistent with the concerns underlying the 'nondirective' counseling requirement." 65 Fed. Reg. at 41,275.

[8] The Rule also bars providers from "support[ing]" or "promot[ing]" abortion "as a method of family planning." 84 Fed. Reg. 7788-89. Insofar as this provision also prevents Title X staff from presenting abortion as an option to patients, it similarly violates the Nondirective Counseling Mandate.

Creates unreasonable barriers to appropriate medical care / Impedes timely access to health care: 42 U.S.C. § 18114(1)-(2). Both the Separation Requirement and the Gag Rule violate the first two prongs of Section 1554 by creating unreasonable barriers, and impeding timely access, to family planning services and abortion.

First, Defendants assume without evidence that there will be no reduction in Title X-funded family planning services,[9] 84 Fed. Reg. at 7723, 7749, 7782, notwithstanding actual evidence that the Rule will cause a decrease in those services. Bailey Decl. ¶¶ 60-82, 86. It is already apparent that many organizations will leave the Title X program—including Planned Parenthood and at least four states[10]—and there is no evidence that new providers will join the program or offer comparable services to those providers who leave the program as a result of the Rule. Evidence from similar state-level legislation barring abortion-affiliated providers from participating in family planning programs demonstrates that the quantity and quality of family planning services inevitably will decrease. *Id*. ¶¶ 69-83.

For example, after the Texas legislature passed multiple measures aimed at defunding Planned Parenthood affiliates, 40% of the state's specialized family planning clinics closed, along with 19% of other family planning providers. *Id*. ¶ 72. Service hours were reduced at many clinics, leading to longer waiting times for patients. *Id.* ¶ 73. Organizations struggled to

[9] In fact, Defendants ignored evidence in the record to the contrary. *See*, *e.g.*, HHS Letter from Jack Lienke, Iliana Paul, & Jason A. Schwartz, Inst. for Policy Integrity at NYU Sch. of Law, to Office of Population Affairs, U.S. Dep't of Health & Human Servs. 4-7 (July 31, 2018) [hereinafter Institute for Policy Integrity Letter] ("The Proposed Rule is likely to reduce the availability and consumption of medical services.").

[10] Letter from Dana Singiser, Vice President of Pub. Policy & Gov't Relations, Planned Parenthood Action Fund, to Alex Azar, Sec'y, U.S. Dep't of Health & Human Servs. 15 (July 31, 2018) [hereinafter PPAF Letter]; Letter from David Y. Ige, Governor, State of Haw., to Alex Azar, Sec'y, U.S. Dep't of Health & Human Servs. 1 (July 30, 2018); Letter from Andrew M. Cuomo, Governor, State of N.Y., to Alex Azar, Sec'y, U.S. Dep't of Health & Human Servs. 2 (July 30, 2018) [hereinafter NY Letter]; Press Release, Kate Brown, Governor, State of Or., Governor Brown on Federal Title X Rollbacks on Access to Reproductive Health (July 30, 2018); Press Release, Jay Inslee, Governor, State of Wash., Protecting Washington Women from Trump Gag Rule (July 30, 2018).

provide patients with the full range of contraceptive methods and saw reductions in the contraceptive methods they offered. *Id.* ¶ 76. 28% of state-funded family planning clinics in the Rio Grande Valley closed, and many others had to raise fees. *Id.*¶¶ 79, 75.[11]

Particularly in rural states like Maine, a reduction in family planning services would significantly impact patients' ability to timely access those services. *See* Hill Decl. ¶ 11; NP Decl. ¶ 9; Jenkins Decl. ¶ 9. Rural areas suffer from shortages of primary and specialty health care providers, making it unlikely that these already-underserved regions will see a proliferation of new Title X applicants to take the place of those leaving the program. Bailey Decl. ¶ 91. If the Rule goes into effect, the PPNNE sites serving over 40% of MFP's patients will no longer offer subsidized Title X care, with no replacement in the offing. Hill Decl. ¶ 56. And if MFP were to lose its Title X funds, it would lose a significant portion of its funding for family planning services and would need to close between 11 and 15 of its current 18 sites, including many of the most rural. *Id.* ¶¶ 26-27. The Rule will accordingly lead to a massive loss of Title X family planning services in Maine, an unreasonable barrier to care.

Second, by requiring Title X providers to physically segregate their Title X family planning services from their abortion-related activities, the Separation Requirement will cause a reduction in abortion services. *See* Bailey Decl. ¶ 119-21. When facilities cease providing abortions altogether in light of the Separation Requirement or concentrate their provision of abortion services at a single location, a significant number of women will have to travel much further distances to obtain legal abortion services. *See infra* Part I.C (discussing undue burden

[11] Similarly, the Iowa legislature voted in 2017 to exclude from Iowa's state-funded family planning program agencies that also provided abortion or operated a facility where abortions were performed. Bailey Decl. ¶ 81. As a result, the number of patients enrolled in the program fell by half and services provided declined by 73%—despite there being $2.5 million remaining in the program that was not spent. *Id.* ¶ 82. In other words, exclusion of established clinics was not resolved by provision of services at other locations, even when funding was available.

on abortion access that will result from the Rule). This is particularly true in Maine: if MFP is forced to stop offering abortion services at its 17 satellite clinics, the distances many women would have to travel to obtain an abortion and the logistical challenges of making those trips would delay or even prevent them from obtaining abortions. *Id.*

The Gag Rule likewise creates unreasonable barriers for patients with unwanted pregnancies to obtain care by barring health care professionals from providing full and accurate information about abortion services and abortion referrals, thereby impeding those patients' ability to timely access abortion care. *See* Wynia Decl. ¶ 32; NP Decl. ¶¶ 15-16.

Interferes with communications regarding treatment options / Restricts full disclosure: 42 U.S.C. § 18114(3)-(4). By prohibiting referrals for and written materials about abortion, limiting provider/patient discussion about abortion, and requiring health care professionals to provide a deliberately misleading list of "comprehensive primary health care providers" in response to a request for an abortion referral, the Gag Rule on its face does exactly that which Section 1554 prohibits: it prevents health care providers from speaking openly with their patients about abortion in response to an unplanned pregnancy. Indeed, it is difficult to imagine a clearer example of interference with communications between patient and provider—or a clearer restriction on the ability of health care providers to disclose all relevant information to patients. The Rule requires health care professionals to refuse any request for an abortion referral. And, to the extent a provider may give patients a restricted list of "comprehensive primary health care providers," even if the patient *directly asks her health care provider* which (if any) of the providers on that misleading list offers abortion services, the provider is prohibited from answering. 84 Fed. Reg. at 7789; *see also* Wynia Decl. ¶¶ 27-28. Without question the Rule

prevents providers from discussing "a full range of treatment options" and fully disclosing "all relevant information" in contravention of the ACA. *See* Wynia Decl. ¶¶ 23, 28.[12]

Violates principles of informed consent and ethical standards: 42 U.S.C. § 18114(5). As attested to by the American Medical Association, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the American Academy of Nursing, and other associations of health care professionals,[13] a health care professional has an ethical obligation not to withhold any medically useful information that a reasonable person would want or need to know in order to make an informed decision. *Id.* ¶¶ 16-17; *see also id.* ¶¶ 19-22, 24. Here, by preventing health care professionals from giving information about or referrals to abortion services, the Rule expressly requires Title X providers to withhold relevant and medically useful information, known to the provider, that a reasonable patient with an unwanted pregnancy would want and, in fact, would need. *Id.* ¶¶ 23-24. In Maine, for example, if a family planning patient in Augusta sought an abortion referral, the referral ban would limit MFP to providing the patient with a list of primary care providers, only one of which provides the requested service—and one that is 80 miles away in Bangor—even though MFP's own nearby facility could meet the patient's needs. Kieltyka Decl. ¶¶ 33-34. Moreover, whether a given abortion provider is suitable for a particular patient requires assessment of the patient's

[12] The prohibition on referrals also violates Section 1554 by limiting the ability of health care professionals to support continuity of care "for the full duration of a patient's medical needs", in violation of the AMA's Code of Medical Ethics, which prohibits patient abandonment. *See* Wynia Decl. ¶ 28.

[13] *See, e.g.*, AMA Letter, *supra* note 4, at 3 ("The inability to . . . provide any and all appropriate referrals, including for abortion services, [is] contrary to the AMA's Code of Medical Ethics.); ACOG Letter, *supra* note 4, at 5 ("These provisions represent an improper intrusion into the patient-physician relationship, the importance of which is underscored in the preamble of the Proposed Rule. . . . The result of such a regulation would be to mislead patients and delay their access to abortion care, placing providers in ethically compromised positions."); AAFP Letter, *supra* note 4 ("The proposed rule would force health care providers to omit important and accurate medical information necessary for patients to make timely, fully informed decisions, encroaching upon physicians' codes of ethics and responsibilities to patients."); AAN Letter, *supra* note 4, at 4 ("These ethical obligations [in the Code of Ethics for Nurses] recognize that a patient's informed consent and access to medically appropriate care is dependent upon both having all treatment options presented and referrals to appropriate providers.").

medical condition, location, preferences, and other needs, an assessment that is best made with assistance from an informed health care professional, rather than by a patient alone. *Id.* ¶¶ 31-32. Accordingly, withholding information about appropriate referrals is incompatible with the ethical obligations of medical professionals in clear violation of Section 1554. Wynia Decl. ¶ 27.

B. The Rule Is Contrary to Title X

Where, as here, an administrative agency has not "stayed within the bounds of its statutory authority," *City of Arlington v. FCC*, 569 U.S. 290, 297 (2013), the rule must be set aside. To determine whether a federal agency has improperly construed a statute it administers, courts apply the test set forth in *Chevron v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). The Court must first determine whether Congress has directly spoken to the precise question at issue, and "if the intent of Congress is clear, that is the end of the matter." *Id.* at 842. Only if Congress's intent is ambiguous does the Court consider whether a regulation is a reasonable construction of the statute. *Id.* at 842-43.

While the *Rust* Court held that the plain language of Title X was ambiguous with respect to the meaning of Section 1008, 500 U.S. at 184, after *Rust*, Congress clarified its intent—that Section 1008 was never intended to (i) limit abortion counseling, including abortion referral, nor (ii) require physical and financial separation of Title X from abortion services—both through explicit legislative action and ratification of HHS's longstanding policies. *See Red Lion Broad. Co. v. F.C.C.*, 395 U.S. 367, 380-81 (1969) ("Subsequent legislation declaring the intent of an earlier statute is entitled to great weight in statutory construction."); *Food & Drug Admin. v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) ("[T]he meaning of one statute may be affected by other Acts, particularly where Congress has spoken subsequently and more specifically to the topic at hand."); *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut.*

Auto Ins. Co., 463 U.S. 29, 45 (1983) ("[I]interpretation of a statute may be confirmed or ratified by subsequent congressional failure to change that interpretation.").

First, after *Rust*, Congress passed the FPAA, which required counseling and referral on all pregnancy options, including prenatal care and delivery, infant care, foster care, adoption, *and pregnancy termination*. *See* 138 Cong. Rec. 9862 (1992) (statement of Rep. Lloyd). In passing the FPAA, members of Congress described the 1988 Rule as, *inter alia*, "bad medicine, bad law, and bad precedent" and as "a step toward two-tier health care in America." *Id.* at 9859 (statement of Rep. Waxman); *id.* at 9860 (statement of Rep. Wyden); *see also* Compl. ¶ 47, dkt. 1 (May 6, 2019). Denouncing the 1988 Rule, Congressman Studds unequivocally stated:

> *When we created the title X program 20 years ago, we did not intend to muzzle health care providers.* But we didn't say that loudly and clearly enough. But this time, let there be no mistake. Title X providers must be able to inform individuals of all pregnancy management options and we must write this explicitly into law.

138 Cong. Rec. at 9872 (emphasis added).

Although HHS entirely ignores the Family Planning Amendments in its discussion of the Rule, the Court should not. That the FPAA was ultimately vetoed does not reduce its importance; it is well-settled that Congress establishes its intent in bills that it passes, regardless of whether the President ultimately signs the bill into law. *See Clifton v. Heckler*, 755 F.2d 1138, 1145 n.15 (5th Cir. 1985) ("Regardless of the President's veto of the bill . . . we find its legislative history instructive on the question of the intended nature of the . . . original [statute]."); *Taylor v. U.S.*, 749 F.2d 171, 174 (3d Cir. 1984) (finding Congress had clarified a legislative term through later-enacted bill despite President declining to sign later bill into law).

Second, Congress has expressed its intent with respect to Section 1008 through its annual appropriations bills. *See Morton v. Ruiz*, 415 U.S. 199 (1974) (looking to annual appropriations

as evidence of whether Congress ratified the agency's interpretation of the statute); *McNabb for McNabb v. Bowen*, 829 F.2d 787, 793 n.6 (9th Cir. 1987) (referring "to reports of the congressional appropriations committee for guidance in determining the proper [interpretation]" of a statute). Congress must effectively reenact Title X every year by appropriating new funds for it, and it has done so for decades without any change to Section 1008—even though HHS's policy requiring nondirective counseling and permitting colocation of Title X and abortion services were reaffirmed in 1993 and have been set forth in regulations since 2000.

In other words, over the 26 years that HHS's interpretation of Section 1008 has stood, Congress has not once taken steps to change it, much less to amend Section 1008. In fact, by consistently including both the condition that Title X funds "shall not be expended for abortion" and the Nondirective Counseling Mandate in its appropriations bills, Congress has recognized the controversy and made its assent to HHS's policy clear. "It is well established that when Congress revisits a statute giving rise to longstanding administrative interpretation without pertinent change, the congressional failure to revise or repeal the agency's interpretation is persuasive evidence that the interpretation is one intended by Congress." *See Commodity Fut. Tr. Comm'n v. Schor*, 478 U.S. 833, 846 (1986); *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 274-75 (1974) (explaining that longstanding interpretation of a statute should be "accord[ed] great weight" "where Congress has re-enacted the statute without pertinent change").

Because "Congress has spoken directly on [this] particular issue," *Maine Medical Center v. Burwell*, 841 F.3d 10, 17 (1st Cir. 2016), and because the Gag Rule and Separation Requirement contradict Congress's stated intent, the Rule cannot stand.

C. The Rule Violates the APA Because It Is Arbitrary and Capricious

The Rule additionally cannot be enforced because it is arbitrary and capricious. 5 U.S.C. § 706(2)(A). An agency action must be based on a "reasoned analysis" that indicates the agency

"examine[d] the relevant data and articulate[d] a satisfactory explanation for its action including a rational connection between the facts found and the choice made." *State Farm*, 463 U.S. at 42-43. When an agency reverses position, however, it must provide "a more detailed justification than what would suffice for a new policy created on a blank slate." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009). The agency acts arbitrarily and capriciously when it fails to offer a "reasoned explanation" for changing course, *id.*, or refuses to consider "serious reliance interests" that the "prior policy has engendered," *Perez v. Mortg. Bankers Ass'n*, 135 S. Ct. 1199, 1209 (2015).

In general, a rule is arbitrary and capricious where 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." *State Farm*, 463 U.S. at 43. "[A]gency action is lawful only if it rests 'on a consideration of the relevant factors,'" and the agency must consider "the advantages *and* the disadvantages" of the proposal before taking action. *Michigan v. EPA*, 135 S. Ct. 2699, 2706-07 (2015). The Rule fails this standard at every step.

1. The Separation Requirement Is Arbitrary and Capricious

Defendants Have Not Supplied a Reasoned Analysis for the Change. Defendants have not offered a single evidence-based reason for the Separation Requirement, much less the "good reasons" that are required when upending an agency's longstanding policy. *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126 (2016). The Rule's only purported justifications for the Separation Requirement are to: (1) protect against the theoretical "risk" of "intentional or unintentional co-mingling of Title X resources with non-Title X resources or programs," 84 Fed. Reg. at 7715; and (2) address the "potential for confusion," *id.* at 7725. But the agency has

failed to "point to any evidence in the administrative record which supports th[e] bald assertion" that these problems even exist. *Natural Resources Defense Council, Inc. v. U.S. EPA*, 824 F.2d 1258, 1286 (1st Cir. 1987). Despite the fact that Title X providers are subject to regular and extensive compliance review by HHS to ensure federal funds are not used for prohibited activities,[14] the Rule does not provide a single example of "co-mingling" funds or of any other Title X violation, much less an example tied to the policy permitting colocation of Title X and abortion services.[15] *See* 84 Fed. Reg. at 7725 (conceding that Medicaid billing issues listed in Proposed Rule are not indicative of abuse of Title X funds); *Maine Ass'n of Interdependent Neighborhoods v. Petit*, 659 F. Supp. 1309, 1322 (D. Me. 1987) (vacating rule based on evidence that was "more or less plucked out of thin air"). Nor have Defendants presented evidence of any "confusion," much less that these regulations would prevent it.

In the absence of evidence to support its hypothetical concerns, the Rule rests entirely on the "conclusions and [] approach in the 1988 regulations with respect to physical and financial separation" and the Court's finding in *Rust* that the 1988 regulations were not arbitrary and capricious. 84 Fed. Reg. 7764. In relying on *Rust*, however, the agency fails to acknowledge that the 1988 Rule was "promulgated in direct response to [] observations" in 1982 reports by the General Accounting Office and Office of the Inspector General that were based on contemporaneous audits of forty-six Title X clinics. *See Rust*, 500 U.S. at 188; 53 Fed. Reg. at 2924. Those reports cannot form the basis of any credible analysis of the Title X program 36

[14] According to OPA, "family planning projects that receive Title X funds are closely monitored to ensure that federal funds are used appropriately and that funds are not used for prohibited activities such as abortion." Angela Napili, Cong. Research Serv., *Title X (Public Health Service Act) Family Planning Program* 22 (Aug. 31, 2017), https://fas.org/sgp/crs/misc/RL33644.pdf.

[15] The Proposed Rule provided *one* example of abortion expenses being charged to a Title X program, 83 Fed. Reg. 25,509-10, which was shown to have been the result of coding error. Letter from Scout Richters, Legal and Policy Counsel, ACLU of Neb., to Diane Foley, Deputy Assistant Sec'y, U.S. Dep't of Health & Human Servs. 2 (July 31, 2018) (explaining that "the Nebraska example [of alleged co-mingling] specifically is incomplete and misleading").

years later, particularly since the Rule itself recognizes that the relevant makeup of Title X clinics has since changed dramatically. 84 Fed. Reg. at 7765. The Rule does not cite a single study, report, or piece of analysis to show that its concerns apply today, much less one that is similar to what was before the Court in *Rust*. *See Sierra Club v. E.P.A.*, 671 F.3d 955, 966 (9th Cir. 2012) (noting that agency stands on "shaky legal ground relying on significantly outdated data, given the amount of time that [new information] was available" before it acted); *cf. Pension Benefit Guar. Corp. v. LTV Corp.*, 496 U.S. 633, 654 (1990) (finding that agency must show it had a rational basis "at the time" of the decision).

Defendants Ignore Reliance Interests. The Rule also wholly fails to acknowledge, as required by law, the "serious reliance interests" engendered by HHS's longstanding policy. *Encino Motorcars*, 136 S. Ct. at 2126; *see also NAACP v. Trump*, 315 F. Supp. 3d 457, 473 (D.D.C. 2018) (observing that agency "demonstrate[d] no true cognizance of the serious reliance interests at issue here—indeed, it does not even identify what those interests are."). Many Title X projects, like Maine Family Planning, are established practices that have developed over the course of decades in facilities shared with abortion providers under the current regime. Hill Decl. ¶ 8. Indeed, Defendants were presented with overwhelming evidence that forcing *post hoc* physical separation of these established practices would be complicated, expensive, and, in many cases, impossible.[16] Yet they refused to take those interests into account, asserting only that *Rust* permits them to reenact their desired interpretation of Section 1008. This is legally insufficient.

[16] *See, e.g.*, Letter from Joseph Alifante, President & CEO, N.J. Family Planning League, to Diane Foley, Deputy Assistant Sec'y, U.S. Dep't of Health & Human Servs. 5 (July 31, 2018) ("NJFPL would have a difficult, if not impossible, task in ascertaining what activities could run afoul of these separation requirements and then trying to accomplish sufficient physical separation.").

Defendants' Explanation Runs Counter to the Evidence Before the Agency. The Separation Requirement relies on at least two false premises: first, that separation is simple and cheap; and second, that there will be no decrease in facilities offering services.

Without supporting cost calculations, Defendants concluded that the Separation Requirement would cost on average $20,000 to $40,000 per site. This is neither correct nor consistent with the evidence in the record. Many providers submitted comments explaining it would cost them hundreds of thousands, and in some instances millions, of dollars to create such separate facilities.[17] For MFP, renovation of its existing Augusta site to create a separate unit for abortion services would cost well over $100,000, with a new building costing potentially over $500,000. Hill Decl. ¶¶ 41-43. At MFP's 17 clinics outside of Augusta, the startup costs to create a new facility in each location would be prohibitive. *See id.* ¶¶ 31-38.

The Rule additionally states that "the Department cannot calculate or anticipate future turnover in grantees" and that such calculations would be "purely speculative" because "[v]arious entities may change their decision to apply to be a grantee or sub-grantees." 84 Fed. Reg. at 7782. Despite these admissions, Defendants still concluded that the Rule would not have "significant impact on access to services" or on patient travel times. *Id.* In fact, abundant evidence was presented that the Rule will substantially reduce the number of Title X providers,[18]

[17] *See, e.g.*, Letter from Jodi Tomlonovic, Executive Director, Family Planning Council of Iowa, to Diane Foley, Deputy Assistant Sec'y, U.S. Dep't of Health & Human Servs. 12 (July 31, 2018) ("[I]t typically costs hundreds of thousands, or even millions, of dollars to locate and open any health care facility (and would also cost much more than $10-30,000 to establish even an extremely simple and limited office), staff it, purchase separate workstations, set up record-keeping systems, etc."); N.Y. Dep't of Health Attachment to N.Y. Letter, *supra* note 10, at 18-19 (highlighting hundreds of thousands of dollars in electronic records costs and thousands of dollars annually in duplicative administrative costs); PPAF Letter, *supra* note 10, at 31-32 ("[B]uilding and renovation costs alone would total $1.2 billion in the first year after the regulation is finalized. This comes to an average cost of nearly $625,000 per affected service site."); *see also* Bailey Decl. ¶¶ 61-63 (examining one-time separation costs).

[18] *See, e.g.*, Institute for Policy Integrity Letter, *supra* note 9, at 4-7 ("The Proposed Rule is likely to reduce the availability and consumption of medical services."); Letter from Rachel Benson Gold, Guttmacher Inst. to Office of Population Affairs, U.S. Department of Health & Human Servs. 19 & tbl. 1 (July 31, 2018) [hereinafter Guttmacher

and studies presented to HHS demonstrate that new grantees are unlikely to provide a sufficient substitute in quantity or quality.[19] In comments, states like Washington with rural areas rebutted the proposition that travel distances would remain the same; in fact, the Rule's Separation Requirement and other provisions would leave over half of Washington's counties without a Title X provider.[20] In many of these areas, patients will have no other option for obtaining family planning services.[21] For Defendants to simply ignore that sites serving over 40% of Title X patients will leave the program, and that substantial areas of the country will be left without Title X providers, is not the reasoned, evidence-based analysis required by the APA.

Similarly, Defendants claim they are unaware 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," 84 Fed. Reg. at 7775, notwithstanding that the record shows that the loss even of Planned Parenthood alone from the Title X program is likely to lead to a "decline in the use of the most effective methods of birth

Letter] ("Available data suggests that the proposed rule would result in far more than 2% of Title X's contraceptive clients losing access to the comprehensive, high-quality services they need to avoid unintended pregnancies, STIs, cervical cancer, and other negative and potentially costly health outcomes."); PPAF Letter, *supra* note 10.

[19] *E.g.*, Letter from Att'ys Gen. of Cal., Conn., Del., Haw., Ill., Iowa, Me., Md., Minn., N.J., N.M., N.C., & D.C., to Alex M. Azar II, Sec'y, U.S. Dep't of Health & Human Servs. 14 (July 30, 2018) [hereinafter Becerra Letter] (explaining that Title X clinics forced to shut their doors cannot be easily replaced"); Bailey Decl. ¶¶ 86-98.

[20] Letter from Att'ys Gen. of Wash., Mass., Or., & Vt., to Alex M. Azar II, Sec'y, U.S. Dep't of Health & Human Servs. 24, 28 att. 1 (July 31, 2018) [hereinafter Ferguson Letter]; *see also* Guttmacher Letter, *supra* note 18, at 9 (noting separation requirements will "effectively exclude" clinics that offer abortion or those that are affiliated with clinics that do so); Compl. ¶¶ 59-61.

[21] *See* Ferguson Letter, *supra* note 20, at 24 (describing inability of FQHCs and rural health centers in Vermont to absorb the needs of all Title X patients if the current Title X clinics became ineligible for Title X funds); Guttmacher Letter, *supra* note 18, at 14 (explaining that in 33% of U.S. counties, there is no FQHC site providing contraceptive services, meaning women living there would could lose access to Title X-supported services altogether).

control and an increase in births among women who previously used long-acting reversible contraception."[22]

Finally, based on these false premises Defendants reached a fatally-flawed conclusion: that there would not be an adverse impact on health outcomes as a result of the Separation Requirement. The Rule fails even to consider changes in access to abortion services as an important health outcome. And it disregards ample evidence that its destruction of the Title X network will result in substantially worse health outcomes as to family planning and to women's health generally, including quality of care, care coordination, integration of services, and other aspects of patients' experiences. As explained in a comment from a non-partisan think tank, "the end result" of the physical separation requirement "is that some women will lose access to some critical health care services, and that loss of access will result in a number of very real health, financial, physical, and psychological consequences for women and their families."[23]

In sum, Defendants promulgated the Rule without any comprehensive assessment of the substantial costs associated with the Separation Requirement, nor of the harms it will cause to health care of those served by the Title X program. *See Council of Parent Attorneys & Advocates, Inc. v. DeVos*, 2019 WL 1082162, at *18 (D.D.C. Mar. 7, 2019) (vacating regulation because agency failed to consider all relevant factors when considering cost of the regulation).

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[22] AAN Letter, *supra* note 4, at 3 (citing Amanda J. Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 New Eng. J. Med. 853 (2016)); *see also* Letter from U.S. House of Representatives, to Alex Azar, Sec'y, Dep't of Health & Human Servs. 7 (July 31, 2018) ("[T]he consequent changes in the Title X system are likely to increase unintended-pregnancy rates in the most vulnerable segments of the population and are thus more likely to increase than to reduce the incidence of abortions." (internal quotation marks omitted) (quoting Janet M. Bronstein, *Radical Changes for Reproductive Health Care—Proposed Regulations for Title X*, 379 New Eng. J. Med. 706 (2018))).

[23] Institute for Policy Integrity Letter, *supra* note 9, at 5; *see also id.* at 5-7 (explaining that the Rule will increase women's transaction costs for receiving care, along with indirect social and economic costs for women—costs HHS failed to consider); Becerra Letter, *supra* note 19 ("A recent report from the United Nations highlighted that placing barriers for low-income women to access health care 'traps many women in cycles of poverty.'")

2. The Gag Rule Is Arbitrary and Capricious.

With respect to the Gag Rule, Defendants likewise failed to engage in a "reasoned analysis," "consider [] important aspect[s] of the problem," or account for the evidence presented. *State Farm*, 463 U.S. at 42-3.

The Rule ignores unequivocal comments from nearly every leading medical association and public health policy organization making clear that the Gag Rule is incompatible with health care professionals' ethics obligations and the standard of care, and that it "will do indelible harm to the health of Americans and to the relationship between patients and their providers."[24] The Rule does not directly address any of these comments, instead noting only that Defendants "disagree[]." 84 Fed. Reg. at 7724.

Defendants also rejected without discussion HHS's own Title X program requirements and national standards of care (known as the "QFP"). The QFP was prepared by a team of experts within HHS and its sub-agencies (CDC and OPA) in 2014, was backed by extensive research, and was fully reaffirmed in December 2017.[25] The QFP requires "client-centered" care, which for pregnant patients includes nondirective "[o]ptions counseling" with "appropriate referrals." QFP at 2, 4, 13-14. And the QFP also emphasizes that pregnancy "[o]ptions counseling should be provided in accordance with the recommendations from professional medical associations such as ACOG and AAP." *Id.* at 14. But the Rule shuns comments from those very medical associations and rejects without discussion the other principles set forth in the

[24] Press Release, Am. Coll. of Obstetricians & Gynecologists, The Final Title X Regulation Disregards Expert Opinion and Evidence-Based Practices (Feb. 26, 2019), https://www.acog.org/About-ACOG/News-Room/Statements/2019/Final-Title-X-Regulation-Disregards-Expert-Opinion-and-Evidence-Based-Practices? (representing more than 4.3 million health care providers).

[25] Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., Providing Quality Family Planning Services (Apr. 24, 2014), https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf (updating recommendations for 2017) (updated version available at https://www.cdc.gov/mmwr/volumes/66/wr/mm6650a4.htm).

QFP—favoring instead directive counseling that withholds information about abortion that patients want and need, and forcing information about prenatal care on patients regardless of whether it is relevant or appropriate.

Moreover, Defendants did not engage in any analysis of the impact of the Gag Rule on *patients* and their health care, much less a "reasoned" analysis. The Rule claims there will be no costs associated with the Gag Rule, 84 Fed. Reg. at 7719, disregarding entirely the costs that will result from putting patients in danger by withholding referrals and delaying access to care. It further states that "[i]nformation about abortion and abortion providers is widely available and easily accessible, including on the internet," 84 Fed. Reg. at 7746, ignoring evidence in the record that many patients of limited means or education lack the "knowledge and ability to navigate the health care system" and/or lack "regular access to communication tools (e.g., internet, phone) that are needed to access and research" this information.[26]

The Rule also fails to explain why patients must be given confusing prenatal referrals that they neither want nor need if they have decided to have an abortion. The only explanation offered in the Rule is that "[p]renatal care is medically necessary for any patient who is pregnant, so referrals for such care do not render counseling directive." 84 Fed. Reg. at 7761. But the Rule does not explain how or why prenatal care could be necessary for a woman who will exercise her right not to continue her pregnancy.[27] Nor does the Rule explain why it does not permit qualified nurses and trained staff to provide "nondirective" pregnancy counseling.

[26] Letter from Brian McIndoe, President & CEO, RyanHealth, to Office of Population Affairs 3 (July 31, 2018); *see also* Letter from James W. Hunt, Jr., President & CEO, Mass. League of Cmty. Health Ctrs., to Office of Population Affairs 3 (July 31, 2018) (explaining that patients with low health literacy may not be able to identify an appropriate health care provider after being given a general list that does not indicate which ones offer specific service sought).

[27] To the extent the Rule suggests prenatal care is deemed "medically necessary" for purposes of whether Medicaid reimbursement is required, 84 Fed. Reg. at 7728, 7730, 7747 & n.75, 7748, 7761, that is irrelevant to this issue and has no bearing on whether such care is appropriate for all patients.

At most, Defendants attempt to justify the Gag Rule generally by claiming it will provide more "flexibility" for applicants that may not have applied to Title X due to purported "burdens on conscience" imposed by the requirement to provide nondirective pregnancy counseling and referrals for abortion. 84 Fed. Reg. at 7719. But Defendants acknowledge that "[t]he Title X statute has coexisted with federal conscience laws for over 40 years" without incident. 84 Fed. Reg. at 7747. Nor is there any evidence that providers of comparable quality and quantity will step in to fill the vast gap in Title X services that will result from the Rule. *See supra* pp. 13, 16-17. Prioritizing hypothetical "new providers who previously were unable to participate in Title X projects due to conscience concerns," 84 Fed. Reg. at 7723, while excluding experienced clinics with a demonstrated ability to provide a full range of family planning options, is unreasonable and undermines a core Title X requirement that projects offer a "broad range" of "effective" family planning methods and services. 42 U.S.C. § 300(a).

Because Defendants have "offered an explanation for its decision that runs counter to the evidence before the agency" and otherwise failed to articulate "a rational connection between the facts found and the choice made" to disregard longstanding, evidence-based standards, the Gag Rule must be set aside. *State Farm*, 463 U.S. at 43.

D. The Rule Violates Plaintiffs' Patients' Fundamental Right To Choose Abortion Before Viability.

The Due Process Clause of the Fifth Amendment protects Plaintiffs' patients'[28] fundamental right to choose abortion before viability. *See Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 847, 879 (1992). That the Rule relates to a "government funding" program does not immunize it from constitutional scrutiny. While the Supreme Court has held that "the

[28] Plaintiffs use the shorthand "Plaintiffs' patients" throughout this section to refer to Plaintiffs' patients seeking abortion at MFP's satellite clinics, which is the group for whom Plaintiffs seek as-applied relief on this claim.

Government has no constitutional duty to subsidize" abortion, *Rust*, 500 U.S. at 201, the government's ability to restrict abortion access remains constrained by the Fifth Amendment. The government can only "treat abortion providers differently" in its programs as long as "the difference in treatment does not unduly burden a woman's right to obtain an abortion." *Planned Parenthood of Ind., Inc. v. Comm'r of Ind.*, 699 F.3d 962, 988 (7th Cir. 2012).

The Rule imposes burdens that vastly outweigh any potential benefits as applied to Plaintiffs' patients. As a result of the Rule, and regardless of whether MFP accepts Title X funds, between 50% and 85% of the clinics in Maine providing abortion services will be forced to stop. Thus, if the Rule goes into effect, patients seeking abortion in Maine will be forced to travel great distances for abortion services, delaying care or else preventing it altogether.

1. The Undue Burden Standard Developed in Casey *and Clarified in* Whole Woman's Health *Requires Searching Judicial Scrutiny.*

Restrictions on abortion are unconstitutional when they impose an "undue burden," meaning when "the '*purpose or effect*' of the [law] '*is to place a substantial obstacle* in the path of a woman seeking an abortion before the fetus attains viability.'" *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2300, 2309 (2016) ("*WWH*") (quoting *Casey*, 505 U.S. at 878). The undue burden test—adopted by the Supreme Court after *Rust* was decided—is a balancing test, requiring "that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Id.* at 2309. After carefully examining the credible evidence, a court may uphold a regulation *only* if the benefits it advances outweigh the burdens it imposes. *Id.* at 2310. Because the undue burden standard is a form of heightened scrutiny, Defendants bear the burden of proving that the Rule *actually* advances a valid government interest through permissible means. *Id.* at 2309. A court cannot simply defer to the government's judgment or

justification for regulating, and "placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving [the government's] legitimate ends." *Id.*

Where, as here, Plaintiffs' claim is an as-applied challenge, Plaintiffs must "show[] that the law has in fact been (or is sufficiently likely to be) unconstitutionally *applied* to [them]." *McCullen v. Coakley*, 134 S. Ct. 2518, 2534 n.4 (2014). Thus, the relevant question is whether the Rule's burdens outweigh its benefits when applied to Plaintiffs' patients.[29]

The undue burden analysis set forth in *Casey* and *WWH* renders any reliance on *Rust v. Sullivan* misplaced. It is no longer sufficient, as it was in *Rust*, to show that the Rule "leaves [a patient] in no different position than she would have been if the Government had not enacted Title X." *Rust*, 500 U.S. at 202.[30] The Court now must ask whether, when "compared to prior law" (here the *existing* Title X program) "the burdens a law imposes on abortion" outweigh "the benefits [that] law[] confer[s]." *WWH*, 136 S. Ct. at 2310-11.[31]

Rust also is distinguishable procedurally and factually. First, the Fifth Amendment claim before the Court in *Rust* was a facial challenge, not the as-applied undue burden claim presented here. Indeed, the Court explicitly left open the possibility of future as-applied challenges. *Id.* at

[29] In an as-applied, challenge, unlike a facial one, a plaintiff need not demonstrate that a "large fraction" of women are unduly burdened by the law. *See, e.g., Britell v. United States*, 204 F. Supp. 2d 182, 190 (D. Mass. 2002) ("With an as-applied challenge . . . 'the bar is necessarily lower': [Plaintiff] has to show that the challenged provision operates unconstitutionally as applied to her."), *rev'd on other grounds*, 372 F.3d 1370 (Fed. Cir. 2004); *Jackson Women's Health Org. v. Currier*, 760 F.3d 448, 458 (5th Cir. 2014) (ordering injunctive relief without applying "large fraction" test).

[30] While the *Rust* Court found that the 1988 Rule did not facially "impermissibly burden" women's right to abortion, 500 U.S. at 201-02, it did not actually weigh the benefits against the burdens of the rule, as is required today.

[31] For purposes of this as-applied challenge, the Court need not, and should not, decide whether *Rust*'s holding that the government does not create an undue burden by refusing to directly fund abortion remains sustainable today. *See Rust*, 500 U.S. at 201-02. Here, the Rule interferes with patients' ability to access abortion services regardless of who pays for the abortion. Post *WWH*, laws that go beyond "refusing to assist" a pregnant person by funding her abortion, and instead "interfere with . . . patients' ability to obtain abortions," *Planned Parenthood Se., Inc. v. Strange*, 33 F. Supp. 3d 1330, 1358 (M.D. Ala. 2014), must be analyzed under *WWH*'s balancing framework.

183 ("[W]e are concerned only with the question whether, on their face, the regulations [are unconstitutional]."). Second, the *Rust* Court considered only burdens associated with the Rule's counseling and referral restrictions, not any burdens resulting from the separation requirement's impact on clinic closures and associated travel distances.[32] *See* 500 U.S. at 201-02.

2. Purported Benefits of the Rule Do Not Outweigh the Substantial Obstacles Placed in the Path of Plaintiffs' Patients.

As discussed *supra* in Part I.C, Defendants have baldly asserted that the Rule's purpose is to "ensure compliance with, and enhance implementation of," the requirements of Section 1008, 84 Fed. Reg. at 7715, without offering evidence in either the NPRM or the Rule that this interest is legitimate or that it is served by the Rule. Under *WWH*, the government cannot simply assert an interest without evidence. 136 S. Ct. at 2310. Accordingly, the purported benefits of the Rule are entitled to little if any weight.

By contrast, the Rule significantly burdens Plaintiffs' patients' access to abortion because: (i) the Rule will shutter a majority of the state's abortion sites, substantially increasing travel distances for patients seeking abortion; (ii) Maine's economic conditions, geography, rurality, and harsh winter weather all compound the burdens of increased travel for patients; and (iii) the Rule will severely limit patients' access to information about abortion. These hurdles will delay patients' access to abortion care and prevent some from accessing abortion altogether.

i. *The Rule Would Significantly Increase Travel Distances.*

As a direct result of the Rule, the number of abortion clinics in Maine will decrease dramatically, resulting in substantial burdens to women who would otherwise receive care at those sites. While abortion access in Maine is already challenging, the Rule will cause either

[32] The Gag Rule alone constitutes an undue burden, notwithstanding *Rust*, under *Casey* and *WWH*. However, the Court need not reach that issue or revisit *Rust*'s holding on that point because the additional burdens created by the new Rule's Separation Requirement, as applied to Plaintiffs' patients in the current context, are dispositive.

85% of abortion sites in Maine to stop providing (if MFP implements the Rule), or the closure of 50%-70% of Maine's abortion sites, including the most rural (if the Rule forces MFP out of the Title X program). The distance between many patients and the closest abortion provider will accordingly increase exponentially. *Compare WWH*, 136 S. Ct. at 2312-13 (striking down admitting privileges requirement that would have closed 50% of abortion clinics in Texas).

If MFP implements the Rule, the loss of 17 abortion sites would result in more than half of Maine women living in counties without an abortion provider, significantly increasing travel distances to providers. Lindo Decl. ¶¶ 8, 12, 16-17; Kieltyka Decl. ¶ 22. Of the women who sought abortions at MFP's satellite clinics over the past 18 months, only 6.1% lived farther than 25 miles from a U.S. abortion provider, and that number would increase to 82.7% if MFP implements the rule, while the percent who lived 50 miles from a provider would jump from less than 1% to 31%. Lindo Decl. ¶ 17.[33] Similarly, if all Maine women of reproductive age whose closest abortion provider is one of MFP's satellite clinics are considered, only 7.9% currently live over 25 miles from an abortion provider, but that number would increase to 76.1%. *Id.* ¶ 16 (Table 2). In addition, no women who sought abortions at MFP's satellite clinics over the past 18 months currently live 100 miles or more from a clinic, but if MFP's satellites close, 15% would have to travel *more than 100 miles* to their nearest clinic. *Id.*; *compare WWH*, 136 S. Ct. at 2302 (striking down law where "the number of women of reproductive age living more than 50 miles from a clinic [] doubled [and] those living more than 100 miles [] increased by 150%").

Alternatively, if MFP does not implement the Rule, the closing of 11 to 15 rural clinic locations will eliminate both abortion *and* family planning services in those locations, and

[33] Out of an abundance of caution, Plaintiffs have calculated distances to nearest abortion provider based on clinics in Maine and neighboring states. However, "the proper formulation of the undue burden analysis focuses solely on the effects within the regulating state." *Jackson Women's Health Org. v. Currier*, 760 F.3d 448, 457 (5th Cir. 2014).

likewise would result in substantial increased travel distances for patients seeking abortion. Lindo Decl. ¶¶ 18-19. Under this scenario, the percentage of patients who sought services at MFP's satellite clinics and who live more than 25 miles from an abortion provider would increase from 6.1% to between 37% and 61%. *Id.* ¶ 18 (Table 3). The percentage of patients who sought services at MFP's satellite clinics living over 50 miles from an abortion provider would likewise increase from less than 1% to anywhere between 13% and 23%. *Id.* Empirical evidence demonstrates that even comparatively small increases in driving distance, like 25 miles, can lead to significant travel-related burdens as well as substantial decreases in access to abortion. Lindo Decl. ¶ 8. "[W]hen a clinic closes, the largest effects are actually felt by women who, prior to the closure, need to travel only short distances, less than 50 miles." *Strange*, 33 F. Supp. 3d at 1358. Thus, the increase in the percentage of Plaintiffs' patients living farther than 25 miles from a U.S. abortion provider that would result from the Rule is highly significant. Lindo Decl. ¶¶ 16-18.

The burden of increased travel distances is compounded by other challenges specific to travel throughout Maine. *See Planned Parenthood of Indiana and Kentucky, Inc v. Comm'r of Indiana State Dep't of Health*, 896 F.3d 809, 824 (7th Cir. 2018) ("*PPINK*") (requiring consideration of impact "based on the reality of the abortion provider and its patients, not as it could if providers and patients had unlimited resources"). Maine's economic conditions, geography, rurality, and harsh winter weather conditions would all exacerbate the burdens associated with drastic increases in driving distances. Lindo Decl. ¶ 40; Kieltyka Decl. ¶¶ 23-24; NP Decl. ¶¶ 6-7, 22, 25; Jenkins Decl. ¶¶ 9, 23-26. Traveling throughout Maine can be extremely time-consuming and difficult because there is only one north-south interstate highway; transportation within and among counties is limited; and there are few public transportation

options outside of Portland. Lindo Decl. ¶¶ 41-43. Thus, traveling additional miles in Maine often takes far longer than it would in other places, and sometimes is impossible, particularly when it requires travel on local or country roads and/or during inclement weather. Lindo Decl. ¶ 30; NP Decl. ¶¶ 6-7; Jenkins Decl. ¶¶ 9, 23.

Moreover, most patients who seek abortion services at MFP have poverty-level incomes. Hill Decl. ¶ 14; Kieltyka Decl. ¶ 24. MFP's low-income patients routinely tell their health care providers that they do not have, and cannot find, the money they need to travel to a clinic in a different city for abortion care. Kieltyka Decl. ¶ 25.[34] Travel can present significant obstacles for people with low incomes, especially those who lack access to public transportation or their own household vehicle. Lindo Decl. ¶¶ 41-43. Increased travel distances also translate to additional travel costs and incidentals. MFP's abortion patients often work in low-wage jobs that do not offer paid time off or sick leave and require unpredictable schedules; childcare is also difficult to schedule and costly. Kieltyka Decl. ¶ 24. These costs can be prohibitive for women who cannot afford to forgo wages or risk job loss. *See Planned Parenthood of Wisconsin, Inc. v. Schimel*, 806 F.3d 908, 919 (7th Cir. 2015) (explaining that a 90-mile trip for abortion services "may be prohibitively expensive" for low-income women in need of abortion services).

ii. *The Rule Will Severely Limit Plaintiffs' Patients' Access to Information About Abortion.*

The challenges imposed by increased travel distances will be further compounded by the fact that, if the Rule goes into effect, MFP and other Title X providers will be restricted from providing information to their patients about where to find these distant abortion providers. *See Casey*, 505 U.S. at 882 (holding that "misleading" abortion patients or providing them with

[34] Because Maine's Medicaid program excludes coverage for abortion in almost all cases, Plaintiffs' low-income patients who are enrolled in or eligible for Medicaid cannot receive state assistance either with the cost of their abortions or with the cost of travel to their appointments. Kieltyka Decl. ¶ 25.

"[un]truthful" information would be an undue burden); *Planned Parenthood Arizona, Inc. v. Humble*, 753 F.3d 905, 915 (9th Cir. 2014) (describing relevant factors to include "ways in which an abortion regulation interacts with women's lived experience, socioeconomic factors, and other abortion regulations"). For many MFP patients, locating abortion providers without assistance from their Title X provider will be difficult, even prohibitively so. Many MFP patients live in communities where other health care professionals are unwilling or unable to provide informed abortion referrals, and many lack reliable access to the Internet or other independent research sources. NP Decl. ¶ 16; Jenkins Decl. ¶¶ 14,16. This effort will cause additional delays for some, and likely will be insurmountable for others. *See* NP Decl. ¶¶ 24-25; Jenkins Decl. ¶¶ 25-26.

iii. *These Obstacles Will Prevent or Delay Abortion Access.*

The effects of the Rule will prevent some of MFP's patients from accessing abortion procedures altogether. *See* Jenkins Decl. ¶ 26; NP Decl. ¶ 25. "[S]tudies reviewing changes in distance that women must travel to obtain an abortion have consistently found that a woman who lives farther from abortion facilities will be less likely to obtain an abortion." *Planned Parenthood Se. v. Strange*, 33 F. Supp. 3d 1330, 1356 (M.D. Ala. 2014); *see also Planned Parenthood of Ark. & E. Okl. v. Jegley*, 2018 WL 3029104 (E.D. Ark. June 18, 2018) (collecting cases). The same is true under the circumstances here. Dr. Lindo estimates that, if MFP implements the Rule, the abortion rate in Maine will drop by 11 to 13%. Lindo Decl. ¶ 39.

Even for women who ultimately manage to find an abortion provider and make the extended trip, the costs and challenges of travel will delay those patients' care. *See Strange*, 33 F. Supp. 3d at 1356 (discussing surveys of women whose abortion access was delayed due to distance from abortion provider); *see also* Lindo Decl. ¶ 43; Jenkins Decl. ¶¶ 25-26; NP Decl. ¶ 22-25. In Maine, patients' options for scheduling this travel are further complicated by the fact

that what would become the only three remaining abortion sites currently provide abortion care only one day per week, which will inevitably lead to further delays. Kieltyka Decl. ¶¶ 18, 21.

Delays in access to abortion care lead to increased health risks for women. While all abortion procedures are safe, the risks, costs, and complexity of abortion increase with gestational age. Bailey Decl. ¶¶ 122-23. Delays also will prevent some women from accessing their preferred, or medically-indicated, abortion procedure. Kieltyka Decl. ¶ 24; Jenkins Decl. ¶¶ 14, 25; NP Decl. ¶ 23. Some women, especially from rural areas, will be unable to travel to a clinic before its gestational limit and so will be prevented from accessing abortion care in Maine altogether. Kieltyka Decl. ¶ 24. Finally, every day a woman remains pregnant, she experiences continued risks of complications and the physical and emotional symptoms of pregnancy.

In sum, Defendants have failed to demonstrate that the purported interests served by the Rule justify the severe burdens imposed on Plaintiffs' patients' fundamental right to abortion. These substantial burdens far outweigh any reasoning based on the potential and hypothetical interests Defendants seek to advance here. As applied to Plaintiffs' patients, the Rule does not further the government's goals any more than the existing Title X program already does, and certainly not to an extent necessary to justify the substantial burdens imposed on Plaintiffs' patients. The Rule is an unconstitutional solution for a problem that does not exist.

E. The Rule Violates the First Amendment Right to Freedom of Speech.

The Gag Rule directly violates MFP's free speech rights. Supreme Court precedent developed after *Rust* was decided demonstrates that First Amendment Free Speech protections are at their zenith when the government seeks to control the form and content of individuals' protected speech—with particular protection for the speech of medical professionals. In violation of these principles, the Gag Rule would prevent health care providers from speaking

honestly with their patients, and would simultaneously compel speech about prenatal referrals even when not medically or ethically appropriate. Such content- and viewpoint-based government control over the speech of medical professionals violates the First Amendment. *NIFLA*, 138 S. Ct. at 2375.

1. Speech Between Medical Professionals and Patients Is Recognized by the Supreme Court as Subject to Paramount First Amendment Protection.

In responding to comments challenging the constitutionality of the Rule, Defendants argue that the ruling in *Rust* renders the Gag Rule acceptable under the First Amendment, in part because *Rust* holds that the government may generally regulate speech within its own programs such that First Amendment protections do not apply. 84 Fed. Reg. at 7759. In rendering this ruling, however, *Rust* explicitly left open the question of whether the patient-provider relationship is a "traditional sphere of free expression" that is "so fundamental to the functioning of our society" that it is entitled to First Amendment protection even when within a government-funded program. 500 U.S. at 192-95, 200.

Since then, courts have come to recognize more explicitly both that (i) these traditional spheres of free expression are worthy of paramount protection from government interference, such that the government cannot control speech within them through conditions on government funds, and (ii) that the patient-provider relationship is such a sphere. In *Legal Services Corp. v. Velazquez*, the Supreme Court first explained that the government cannot "use an existing medium of expression," like the attorney-client relationship, and "control it, in a class of cases, in ways which distort its usual functioning," 531 U.S. 533, 543 (2001).[35] "The First Amendment

[35] The *Velazquez* Court distinguished *Rust* on two bases specific to the facts before the Court at the time *Rust* was decided: (1) because "[t]here, a patient could receive the approved Title X family planning counseling funded by the Government and later could consult an affiliate or independent organization to receive abortion counseling," whereas the program in *Velazquez* precluded activity through alternative channels, 531 U.S. at 547; and (2) because,

for[bids] the Government from using the forum [of expression] in an unconventional way to suppress speech inherent in the nature of the medium." *Id.*; *see also Rosenberger v. Rector & Visitors of Univ. of Virginia*, 515 U.S. 819, 834 (1995) (requiring viewpoint neutrality in government's provision of financial benefits). And in *NIFLA*, the Supreme Court made clear that "speech is not unprotected merely because it is uttered by professionals," and that speech by medical professionals cannot be limited or compelled based on the whims of the government. *See NIFLA*, 138 S. Ct. at 2371-74 (striking down state law that forced licensed medical providers to provide their patients with government-mandated pregnancy information).

NIFLA clarified that because "doctors help patients make deeply personal decisions, and their candor is crucial," regulating the content of medical professionals' speech "pose[s] inherent risk that the Government seeks not to advance a legitimate regulatory goal, but to suppress unpopular ideas or information." 138 S. Ct. 2774. Similarly, other courts have found that regulations constituting "state attempts to compel physicians to deliver its message, especially when that message runs counter to the physician's professional judgment and the patient's autonomous decision about what information she wants" go beyond permissible interference with the provider-patient relationship. *Stuart v. Camnitz*, 774 F.3d 238, 255 (4th Cir. 2014) (invalidating North Carolina law compelling abortion providers to speak government message about pregnancy); *see also Wollschlaeger v. Governor, Fla.*, 848 F.3d 1293, 1311 (11th Cir. 2017) (en banc) (invalidating Florida law that prevented physicians from discussing gun ownership and safety with patients); *Conant v. Walters*, 309 F.3d 629, 636 (9th Cir. 2002)

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in *Velazquez*, there was no "programmatic message of the kind recognized in *Rust*," *id.* at 548. The facts today stand in stark contrast. In Maine, for example, due to rurality and poverty, patients cannot consult any other organization to receive abortion counseling because MFP is their only access to a health care provider. *See* Hill Decl. ¶¶ 11, 37; Jenkins Decl. ¶ 15.

(enjoining federal law that prohibited physicians from communicating with their patients about medical marijuana). Because the Gag Rule regulates the content of patient-provider communications, First Amendment protections apply.

*2. The Gag Rule is Subject to Heightened Scrutiny Under Post-*Rust *Jurisprudence.*

Since *Rust*, the Supreme Court has expanded and increased scrutiny regarding several significant categories of suspect speech regulation—each of which is directly implicated here. The Gag Rule mandates government-compelled speech, and imposes speech requirements that discriminate based on both content and viewpoint, all of which have been recognized in recent years as particularly pernicious and subject to heightened scrutiny. *See, e.g., Janus v. Am. Fed'n of State, Cty., & Mun. Employees, Council 31*, 138 S. Ct. 2448, 2464 (2018) ("When speech is compelled, . . . individuals are coerced into betraying their convictions. Forcing free and independent individuals to endorse ideas they find objectionable is always demeaning . . . ."); *Reed v. Town of Gilbert*, 135 S. Ct. 2218, 2226-28 (2015) (finding content-based speech discrimination "presumptively unconstitutional"); *NIFLA*, 138 S. Ct. at 2379 (Kennedy, J., concurring) (Viewpoint discrimination occurs when the "government seeks to impose its own message in the place of individual speech, thought, and expression.").[36]

Heightened scrutiny now applies "whenever the government creates a regulation of speech because of disagreement with the message it conveys," and this principle has "great relevance in the fields of medicine and public health, where information can save lives." *Sorrell*

[36] While the majority in *NIFLA* did not ultimately decide if the challenged California law was viewpoint-based, the Court faulted the law in part because it excluded federal clinics and state funded clinics from its requirements, as the State's selective application of the law suggested discrimination based on viewpoint. *See NIFLA*, 138 S. Ct. at 2376. Nowhere did the Court attempt to distinguish *Rust*, nor did it state that the First Amendment does not apply or applies differently to clinics that are funded by the government.

v. IMS Health Inc., 564 U.S. 552, 566 (2011); *see also Greater Baltimore Ctr. for Pregnancy Concerns, Inc. v. Mayor & City Council of Baltimore*, 879 F.3d 101, 112 (4th Cir. 2018) ("Especially in this context [of speech related to abortion], content-based regulation 'raises the specter that the government may effectively drive certain ideas or viewpoints from the marketplace.'"), *cert. denied*, 138 S. Ct. 2710 (2018); *NIFLA*, 138 S. Ct. at 2374-75 ("[T]he people lose when the government is the one deciding which ideas should prevail.").

By forcing health care professionals to speak a particular message—namely, referrals for prenatal care—and banning referrals for abortion, the Gag Rule clearly is content-based compelled speech. *See NIFLA*, 138 S. Ct. at 2380 (Breyer, J., dissenting).[37] It is also viewpoint-based because it favors referrals for prenatal care and adoption over referrals for abortion.

Moreover, the Gag Rule regulates *how* a health care professional may provide pregnancy options counseling, by contrast with the 1988 Rule, which simply banned any counseling once a woman was diagnosed as pregnant. *Compare* 53 Fed. Reg. at 2933 ("[G]iven that the Title X projects do not provide pregnancy services, it is unnecessary for them to provide counseling with respect to such services."). As discussed above, under the Gag Rule the doctor or APP *must* provide information about continued pregnancy or adoption in conjunction with information about abortion, even if the patient does not want this information or the provider does not believe the provision of such information is appropriate. Yet a physician or APP may counsel a patient only about prenatal care and adoption.

[37] The Gag Rule goes further than the restrictions struck down in *NIFLA*, as the *NIFLA* regulations simply required that a sign be posted. Here, the Gag Rule controls what medical professionals themselves both are able to and are required to say, as well as written materials. *See Ohralik v. Ohio State Bar Ass'n*, 436 U.S. 447, 457 (1978) (observing difference between written advertisements that "leave[] the recipient free to act . . . or not" and "in-person solicitations" that "may exert pressure and often demand[] an immediate response").

Finally, the Gag Rule, unlike the *Rust* version, is speaker-based, as HHS would ban anyone except physicians and APPs from providing counseling on pregnancy options that includes abortion.

In practice, the Rule requires a patient's trusted medical provider to rebuff questions about where to obtain an abortion even in the middle of an appointment or consultation, perhaps while the patient is partially disrobed or in the middle of being examined in some way. *See* Jenkins Decl. ¶¶ 16-18, 21; Kieltyka Decl. ¶¶ 32-35. In this manner, the Rule forces providers to act as the government's mouthpiece to convey its preferred message about pregnancy options, without any relationship to informing the patient of the risks and benefits of a particular medical procedure. *See NIFLA*, 138 S. Ct. at 2373.[38]

3. The Rule Fails any Level of Heightened Scrutiny.

Here, as in *NIFLA*, there is no need to determine if strict or intermediate scrutiny applies, as the Rule fails even intermediate scrutiny. *NIFLA*, 138 S. Ct. at 2375. The Gag Rule is not sufficiently tailored to *further* a substantial government interest. It is not substantially related to Defendants' minimal purported interests, as the existing Title X program already accomplishes these goals through less burdensome means. Indeed, Defendants have not put forth any record of Title X violations to show a need for this Rule in the first place. *See supra* pp. 24-25 & n.15. But, even if Defendants had demonstrated a need to inform Title X patients about the government's policy against funding abortion, they could accomplish this goal via less intrusive means, such as the methods suggested in *NIFLA*, which included "a public-information campaign" or posting information "on public property near" clinics. *See NIFLA*, 138 S. Ct. at

[38] Because the Rule's restrictions on speech for abortion counseling and referral do "not facilitate informed consent to a medical procedure," *Casey*'s free speech analysis does not apply. *See NIFLA*, 138 S. Ct. at 2373.

2376. Because requiring providers to speak in a manner with which they disagree is highly invasive and insufficiently tailored, the Gag Rule violates the First Amendment.

F. As-Applied to MFP, the Rule Unconstitutionally Conditions Funding on Relinquishing Its Freedom of Speech.

Even if the Rule were not a facial violation of Title X providers' First Amendment rights, as applied to MFP it is an unconstitutional condition on MFP's right to freedom of speech.

Because the First Amendment prohibits both direct and indirect burdens on speech, under the doctrine of "unconstitutional conditions" the government may not take funds away from an entity based on the exercise of the right to free speech. "[I]f the government could deny a benefit to a person because of his constitutionally protected speech or associations, his exercise of those freedoms would in effect be penalized and inhibited . . . allow[ing] the government to 'produce a result which [it] could not command directly.'" *Perry v. Sindermann*, 408 U.S. 593, 597 (1972). This is precisely what the Rule does to MFP: it conditions funding on MFP relinquishing its constitutional right to freedom of speech. Indeed, the risk of coercion is particularly troubling with respect to MFP because Title X funds comprise a material portion of MFP's total budget, approximately 27%. Hill Decl. ¶ 15; *cf. Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 581 (2012) (holding that threatened defunding of approximately 20% of a state's budget "is much more than 'relatively mild encouragement'—it is a gun to the head").

While the *Rust* Court rejected a free speech unconstitutional conditions claim, Plaintiffs' unconstitutional conditions claims here are distinguishable. First, *Rust* explicitly left open as-applied challenges. *See Rust*, 500 U.S. at 183 ("[W]e are concerned only with the question whether, on their face, the regulations [are unconstitutional]."); *id.* at 195 (noting "we do not have before us any application by the Secretary to a specific fact situation"). Second, more recent Supreme Court precedent emphasizes that, while the government may "specify the

activities [it] wants to subsidize," funding conditions are unconstitutional where they "seek to leverage funding to regulate speech outside the contours of the program itself." *Agency for Int'l Dev. v. All. for Open Soc'y Int'l, Inc.*, 570 U.S. 205, 214-15 (2013). Third, since *Rust*, courts have clarified that the government's ability to choose not to fund abortion does not allow it to prohibit abortion-related advocacy. *See, e.g.*, *Planned Parenthood of Cent. N.C. v. Cansler*, 877 F. Supp. 2d 310, 319-20 (M.D.N.C. 2012) ("[A]lthough the State may choose not to fund abortions or abortion-related services, the State may not 'condition participation in a government program or receipt of a government benefit . . . upon an applicant's exercise of protected rights,' such as the right to advocate for and provide abortion-related services.").

With respect to MFP, the Rule goes beyond dictating the contours of the Title X program to "significantly impinge" upon the provider-patient relationship. *See Rust*, 500 U.S. at 200. Because MFP's providers often are their patients' only point of contact with the health care system, the intimate relationship of trust between MFP providers and patients is "significantly impacted" by the Rule. Jenkins Decl. ¶ 18; Wynia Decl. ¶¶ 17-30. Even in instances where patients have access to other providers, it is no substitute for the dialogue between MFP providers and their patients. For example, MFP sometimes sees patients only after they have already received dangerously inaccurate information about abortion. Jenkins Decl. ¶ 16. Without MFP, patients throughout Maine will have nowhere else to turn for reliable health care services and information.

G. The Rule Is Unconstitutionally Vague

Under the Due Process Clause of the Fifth Amendment, a law must "give fair notice of conduct that is forbidden or required," and provide "precision and guidance" sufficient to prevent Defendants from acting in "an arbitrary or discriminatory way." *Fox*, 567 U.S. at 253.

The Rule does not meet this test. The Separation Requirement is described through a list of non-exclusive and unclear factors, which provide little guidance on what providers actually need to do in order to ensure compliance (*e.g.*, does compliance require separate entrances and rooms, or entirely separate buildings?). *See supra* p. 10. The Gag Rule similarly offers no guidance on how providers can offer any options counseling on abortion in a manner that does not somehow indirectly "promote" or "support" abortion. *See supra* p. 15 & n.8. At the same time, Defendants will have seemingly unbridled discretion to enforce the Rule in unforeseeable ways. *See, e.g.*, 84 Fed. Reg. at 7789.

Put simply, if the Rule goes into effect on May 3, Title X providers who stay in the program will have no idea what to do next and will be vulnerable to arbitrary enforcement. Because these provisions of the Rule do not give fair notice and lack the "precision and guidance" needed to prevent Defendants from acting in "an arbitrary or discriminatory way," *Fox*, 567 U.S. at 253, the Rule is not just unworkable, it is unconstitutional.

II. PLAINTIFFS WILL SUFFER IRREPARABLE HARM ABSENT A PRELIMINARY INJUNCTION

Absent a preliminary injunction, Plaintiffs and their patients will suffer ongoing and irreparable harm when the Rule goes into effect on May 3. As a threshold matter, where a Plaintiff establishes a constitutional violation, no further showing of irreparable injury is necessary. *See Elrod v. Burns*, 427 U.S. 347, 373 (1976) ("The loss of constitutional freedoms . . . unquestionably constitutes irreparable injury."); *Wal-Mart Stores, Inc. v. Rodriguez*, 238 F. Supp. 2d 395, 421 (D.P.R. 2002) ("A presumption of irreparable harm flows from and is triggered by an alleged deprivation of constitutional rights."), *vacated pursuant to a settlement agreement on appeal*, 322 F.3d 747 (1st Cir. 2003). This is especially true in cases implicating the First Amendment, "given the clear irreparable harm caused by censorship, the

hardship that censorship imposes on citizens, and the strong public interest in upholding constitutional rights." *Cushing v. McKee*, 738 F. Supp. 2d 146, 154 (D. Me. 2010); *see also Asociación de Educación Privada de P.R., Inc. v. García–Padilla*, 490 F.3d 1, 21 (1st Cir. 2007) (noting that loss of First Amendment freedoms "unquestionably constitutes irreparable injury").

Additionally, the Rule will irreversibly gut the provision of family planning services in Maine and nationwide, as many Title X providers will be forced to immediately drop out of the program. Others will spend their limited resources complying with the Separation Requirement. The missing providers and decrease in funds available for patient care will result in a reduction in services provided and clinic closures, along with increased wait times for remaining services, and greater costs for providers and low-income patients. *See* Bailey Decl. ¶¶ 67-80. MFP will lose on May 3, at a minimum, one of its largest subrecipients, PPPNE. It typically takes at least four months for MFP to gain approval for a new subrecipient once identified—and no such replacement has yet been found—during which time there will be a large reduction in Title X-covered services in the Portland area. Hill Decl. ¶¶ 57. The funding that would have served those patients will be irretrievably lost. And if MFP cannot find a replacement, it will be placed at an ongoing disadvantage in trying to reestablish coverage at a later date. *Id.* ¶ 58.

Critical health care services will fall out of reach for many women, such as clinical breast exams, pap tests, and contraceptive care. Bailey Decl. ¶¶ 96-97, 108. Predictably, the people most affected by this outcome will be the most vulnerable populations—the very people Title X was instituted to protect—including low-income women, women with children, minorities, adolescents, and victims of domestic violence. *Id.* ¶¶ 99, 102-03, 74 & n.184.

At the same time, implementation of the Rule within the program and at MFP will immediately require health care professionals to violate their ethical principles in their regular

interactions with patients, damaging the ongoing relationships of trust that undergird the program. Wynia Decl. ¶¶ 17, 23; NP Decl. ¶¶ 17-19; Jenkins Decl. ¶¶ 17-21. Women who are misled or denied information about abortion providers will sustain delays in receiving abortion care, which in turn increases health risks, increases the costs of a procedure that many patients already can barely afford, and will prevent some women from accessing their preferred type of abortion procedure. *See supra* pp.38-39. And the Rule will prevent some women from accessing abortion care altogether, requiring those patients to give birth or else potentially resort to unsafe methods outside the medical system to end their pregnancies. *Id.*

In sum, the harms imposed by the Rule will include widespread violations of constitutional rights, the wholesale disruption of the nation's only dedicated family planning program, and significant negative impact on patient care and patient health. These harms are severe and irreparable such that an injunction is required.

III. BALANCE OF EQUITIES AND PUBLIC INTEREST WARRANTS A PRELIMINARY INJUNCTION

Plaintiffs have demonstrated that, absent an injunction, they and their patients will suffer irreparable injury. By contrast, Defendants face no injury from an injunction; it will merely preserve the longstanding status quo of the existing Title X program while questions about the lawfulness of the Rule's drastic changes to the Title X program are adjudicated. *See Bos. Duck Tours, LP v. Super Duck Tours, LLC*, 531 F.3d 1, 11 (1st Cir. 2008) ("[I]ssuing an injunction will burden the defendants less than denying an injunction would burden the plaintiffs."). In the meantime, the integrity of the Title X program will continue to be protected under existing law.

Moreover, the public interest will be served, rather than harmed, by injunctive relief. Because Plaintiffs are likely to succeed on the merits of both their APA and constitutional claims, an injunction serves the public's interest. *See Awad v. Ziriax*, 670 F.3d 1111, 1132 (10th

Cir. 2012) ("[I]t is always in the public interest to prevent the violation of a party's constitutional rights."). Without a preliminary injunction, women seeking abortion and family planning services, as well as the medical professionals providing those services, will suffer unlawful harms to their legal rights and unjustified burdens to their constitutional rights.

IV. RELIEF REQUESTED

For all of the reasons set forth above, Plaintiffs request that the Rule be enjoined in full in order to provide Plaintiffs with necessary and appropriate relief. *See, e.g.*, *Franciscan Alliance v. Burwell*, 227 F. Supp. 3d 660, 695 (N.D. Tex. 2016) (noting that a "nationwide injunction is appropriate when a party brings a facial challenge to agency action under the APA" and when a broad rule's "harm is felt by healthcare providers and states across the country").

In the alternative, Plaintiffs request that the Court stay the effective date of the Rule under Section 705 of the APA pending adjudication of this case on the merits. Section 705 permits this Court to "postpone the effective date of an agency action" where "necessary to prevent irreparable injury . . . pending conclusion of the review proceedings." 5 U.S.C. § 705. The Court applies the same four-factor test used to evaluate requests for preliminary injunctive relief in considering a stay request. *Bauer v. DeVos*, 325 F. Supp. 3d 74, 104-05 (D.D.C. 2018). Here, Plaintiffs have satisfied the four-factor showing required of a request for preliminary injunctive relief. The Court should therefore stay all implementation deadlines in the Final Rule pending resolution of this case on the merits to avoid irreparable injury to Plaintiffs.

CONCLUSION

For the foregoing reasons, Plaintiffs' Motion for Preliminary Injunction should be granted.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on March 25, 2019, I electronically filed the within Memorandum in Support of Motion for Preliminary Injunction with the Clerk of Court using the CM/ECF system, which will send notification of such filing to counsel of record.

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