No. 19-35386

IN THE UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

STATE OF OREGON, et al.,

Plaintiffs-Appellees,

v.

ALEX M. AZAR II, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants-Appellants.

AMERICAN MEDICAL ASSOCIATION, et al.,

Plaintiffs-Appellees,

v.

ALEX M. AZAR II, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

ANSWERING BRIEF OF PLAINTIFFS-APPELLEES OREGON, NEW YORK, COLORADO, CONNECTICUT, DELAWARE, DISTRICT OF COLUMBIA, HAWAII, ILLINOIS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, NEVADA, NEW JERSEY, NEW MEXICO, NORTH CAROLINA, PENNSYLVANIA, RHODE ISLAND, VERMONT, VIRGINIA, AND WISCONSIN

ELLEN F. ROSENBLUM
Attorney General
State of Oregon
BENJAMIN GUTMAN
Solicitor General
JONA J. MAUKONEN
Senior Assistant Attorney General
1162 Court Street NE
Salem, Oregon 97301-4096
benjamin.gutman@doj.state.or.us
Telephone: (503) 378-4402

LETITIA JAMES
Attorney General
State of New York
BARBARA D. UNDERWOOD
Solicitor General
ANISHA S. DASGUPTA
Deputy Solicitor General
JUDITH N. VALE
Senior Assistant Solicitor General
New York State Office of the Attorney General
23rd Floor, 28 Liberty Street
New York, NY 10005

TABLE OF CONTENTS

INTRODUCTION 1

STATEMENT OF JURISDICTION 2

ISSUE PRESENTED 2

BACKGROUND 3

A. Statutory and Regulatory Framework 3

1. Title X 3

2. The 1981 Guidelines 4

3. The 1988 Regulations 5

4. Congress's Mandate That All Pregnancy Counseling in Title X Be Nondirective (the Nondirective Mandate) 6

5. The Affordable Care Act (ACA) 9

B. The Final Rule 10

C. Procedural Background 10

1. The Preliminary Injunction 11

2. The Motions Panel Stay Opinion 13

SUMMARY OF ARGUMENT 13

ARGUMENT 16

THE PRELIMINARY INJUNCTION PROPERLY PRESERVES THE STATUS QUO 16

A. The States Are Likely to Succeed on the Merits 17

1. The Final Rule is likely contrary to law. 17

a. The Final Rule likely violates Congress's mandate that "all pregnancy counseling" in

Title X be "nondirective." 17

b. The Final Rule's separation requirements and the counseling requirements likely violate § 1554 of the ACA 29

i. The Final Rule likely violates § 1554 29

ii. Plaintiffs did not waive their § 1554 claim. 32

iii. Defendants' other arguments are meritless 35

c. Defendants misplace their reliance on *Rust* and the presumption against implied repeal. 36

2. The Final Rule is arbitrary and capricious because HHS failed to adequately address the significant detriment it would cause to the Title X program and public health. 40

B. The district court did not abuse its discretion in finding that plaintiffs and the public will suffer irreparable harm. 46

C. The district court did not abuse its discretion over the scope of the injunction. 50

CONCLUSION 53

TABLE OF AUTHORITIES

Cases

Branch v. Smith,
538 U.S. 254 (2003) 37

Brown v. Gardner,
513 U.S. 115 (1994) 27

California v. Azar,
2019 WL 1877392 (N.D. Cal. Apr. 26, 2019) 11, 17, 25, 31, 33, 35, 36

California v. Azar,
911 F.3d 558 (9th Cir. 2018) 16, 47, 48

Chevron, U.S.A., Inc. v. NRDC,
467 U.S. 837 (1984) 38, 39

Cisneros v. Alpine Ridge Group,
508 U.S. 10 (1993) 35

Earth Island Inst. v. Ruthenbeck,
490 F.3d 687 (9th Cir. 2007) 52

Encino Motorcars, LLC v. Navarro,
136 S. Ct. 2117 (2016) 46

Epic Systems Corp. v. Lewis,
138 S. Ct. 1612 (2018) 38, 39

Getty v. Fed. Savs. & Loan Ins. Corp.,
805 F.2d 1050 (D.C. Cir. 1986) 41

Hernandez v. Sessions,
872 F.3d 976 (9th Cir. 2017) 50

Idaho Sporting Cong, Inc. v. Rittenhouse,
305 F.3d 957 (9th Cir. 2002) 34

Judulang v. Holder,
565 U.S. 42 (2011) 46

Koretoff v. Vilsack,
707 F.3d 394 (D.C. Cir. 2013) 33

Lair v. Bullock,
798 F.3d 736 (9th Cir. 2015) 17

Lands Council v. McNair,
629 F.3d 1070 (9th Cir. 2010) 34

Mayor and City Council of Baltimore v. Azar,
2019 WL 2298808 (D. Md. May 30, 2019) 11, 17

McDermott Int'l, Inc. v. Wilander,
498 U.S. 337 (1991) 25

MD/DC/DE Broadcasters Ass'n v. FCC,
236 F.3d 13 (D.C. Cir. 2001) 52

Michigan v. EPA,
135 S. Ct. 2699 (2015) 40

Miller v. Clinton,
687 F.3d 1332 (D.C. Cir. 2012) 35

Motor Vehicle Manufacturers Ass'n v. State Farm Mutual Auto Ins. Co.,
463 U.S. 29 (1983) 40, 43, 44

National Ass'n of Home Builders v. Defenders of Wildlife,
551 U.S. 644 (2007) 38

National Family Planning & Reproductive Health Assoc., Inc. v. Sullivan,
979 F.2d 227 (D.C. Cir. 1992) 5, 6

Native Ecosystems Council v. Dombeck,
304 F.3d 886 (9th Cir. 2002).....34

Portland Gen. Elec. Co. v. Bonneville Power Admin.,
501 F.3d 1009 (9th Cir. 2007)..... 32, 33

Rodriguez v. Robbins,
715 F.3d 1127 (9th Cir. 2013).....49

Rust v. Sullivan,
500 U.S. 173 (1991) 2, 6, 7, 14, 17, 36, 37, 38, 46, 49

Sierra Club v. Pruitt,
293 F. Supp. 3d 1050 (N.D. Ca. 2018).....32

Summers v. Earth Island Inst.,
555 U.S. 488 (2009) 52

Trump v. Int'l Refugee Assistance Project, 137 S. Ct. 2080 (2017).....51

United States v. Able Time, Inc.,
545 F.3d 824 (9th Cir. 2008).....32

Washington v. Azar,
2019 WL 1868362 (E.D. Wash. Apr. 25, 2019) 11, 17

Whole Woman's Health v. Hellerstedt,
136 S. Ct. 2292 (2016) 53

Statutes & Constitutional Provisions

20 U.S.C. § 1161k(c)(4)(A).....23

38 U.S.C. § 1720D(b)(2) 23

42 U.S.C. § 18112.....35

42 U.S.C. § 18113 35
42 U.S.C. § 18114 ..... 9, 30, 35, 36, 37, 39
42 U.S.C. § 18116(a) 39
42 U.S.C. § 238n 43
42 U.S.C. § 254c-6(a)(1) 21, 26, 27
42 U.S.C. § 300a-6 3
42 U.S.C. § 300a-7 43
42 U.S.C. § 300ff-33(g)(1)(B)(ii) 23
42 U.S.C. § 3020e-1(b) 23
5 U.S.C. § 705 ..... 50, 51
5 U.S.C. § 706(2) 52
Pub L. No. 104-134, 110 Stat. 1321-221 (1996) 7
Pub. L. No. 111-117, 123 Stat 3034 (2009) 43
Pub. L. No. 115-245, 132 Stat. 2981, 3070–71 (2018) 7
Pub. L. No. 91-572, § 2(1), 84 Stat. 1504 (1970) 3
US Const, Amend I 36
US Const, Amend V 36

Other Authorities

116 Cong. Rec. 37,375 (1970) 5
137 Cong Rec. 18,491 (1991) 7
138 Cong. Rec. H2826 (Apr. 30, 1992) 21
141 Cong. Rec. H8249 (Aug. 2, 1995) 8
141 Cong. Rec. H8250 (Aug. 2, 1995) 8
141 Cong. Rec. H8252 (Aug. 2, 1995) 8, 25
146 Cong. Rec. H2718 (May 9, 2000) 22
American Academy of Pediatrics, Committee on Adolescence, Counseling the Adolescent About Pregnancy Options, Pediatrics, Vol. 83(1) (1989) 4

American Academy of Pediatrics,
Committee on Adolescence, Options Counseling for the Pregnant Adolescent Patient ("AAOP Counseling"),
Pediatrics Vol. 140(3) (2017) 4, 5

Angela Napili,
Cong. Research Serv., R 45181,
Family Planning Program under Title X of the Public Health Service Act
(Updated October 15, 2018) 44

H.R. 2707, 102d Cong., § 514 (1992) 7

H.R. Rep. 102-204 (1991) 8, 24

HHS, Office of Population Affairs,
Title X Family Planning Annual Report,
2016 National Summary (Aug. 2017) 31

Loretta Gavin, Susan Moskosky, et al.,
Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs,
Morbidity and Mortality Weekly Report,
Recommendations and Reports No. 4 (April 25, 2014) 23

S. 323, 102d Cong. (1992) 7, 25

Title X Regulations (The Gag Rule): Health Implications for Poor Women, Hr'g of the S. Comm. on Labor & Human Resources
(May 16, 1991) 8, 20

U.S. Dep't of Health & Human Services,
Health Resources & Services Administration,
Report to Congress: The Infant Adoption Awareness Training Program
(Nov. 2002) 4, 27

U.S. Department of Health & Human Services,
Program Guidelines for Project Grants for Family Planning Services
(1981) 5

Regulations

53 Fed. Reg. 2922 (1988) 5, 6, 25

58 Fed. Reg. 7464 (1993) 6

65 Fed. Reg. 41,270 (2000) 4, 5, 9, 19, 23, 26, 38

83 Fed. Reg. 25,502 (2018) 34, 43
84 Fed. Reg. 23,170 (2019) 42
84 Fed. Reg. 7714 (2019)…….10, 18, 19, 20, 21, 22, 27, 28, 29, 31, 32, 34, 37, 40, 42, 43, 44

.

APPELLEES' BRIEF

INTRODUCTION

The plaintiff States—Oregon, New York, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, North Carolina, Pennsylvania, Rhode Island, Vermont, Virginia, and Wisconsin, and the District of Columbia—brought this suit to challenge a new federal regulation (the Final Rule) that drastically changes the rules applicable to the Title X program. The district court (McShane, J.) issued a preliminary injunction to preserve the status quo and prevent irreparable harm to the plaintiff States, their residents, and the public health.

The Court should affirm. Title X funds vital family-planning and reproductive healthcare services for low-income patients. As the district court found, the Final Rule will reverse the rules that have governed Title X for decades and decimate the program by forcing providers to violate medical ethics and prevailing standards of medical care, or else leave the program. The resulting exodus of providers will cause more unwanted pregnancies, more abortions, and less disease screening. The district court properly exercised its broad discretion in concluding that these irreparable public-health harms warranted preliminarily enjoining the Rule—particularly given that the federal

government will not suffer any irreparable harm from simply maintaining the status quo pending judicial review.

The court also correctly concluded that the States are likely to prevail on the merits. The Final Rule is contrary to two federal statutes and is arbitrary and capricious, in violation of the Administrative Procedure Act (APA). Contrary to defendants' principal argument on appeal, *Rust v. Sullivan*, 500 U.S. 173 (1991), does not control. The statutes that the Final Rule violates were both enacted after *Rust*, and thus were not addressed by *Rust*. And *Rust* was based on a different and now-outdated administrative record.

STATEMENT OF JURISDICTION

Plaintiff States agree with defendants' statement of jurisdiction.

ISSUE PRESENTED

Did the district court abuse its discretion in granting a preliminary injunction in view of the plaintiff's likelihood of success on three independently sufficient grounds, the harm plaintiffs would suffer without an injunction, and the balance of harms and public interest?

BACKGROUND

A. Statutory and Regulatory Framework

1. Title X

Enacted in 1970, Title X funds grants to States and other entities to provide family-planning services and reproductive healthcare to patients who have low incomes, live in rural communities, or face other barriers to accessing medical care. (*See* SSER5–8, 52).[1] *See* Pub. L. No. 91-572, § 2(1), 84 Stat. 1504 (1970).[2] The contraceptive services provided by Title X have substantially reduced the number of unintended pregnancies and abortions in the plaintiff States. (PSER142; SSER22–24, 62–63, 79–81). And the vaccinations, tests for sexually transmitted infections, and cancer screenings that Title X enables significantly enhance patient health. (SSER4–5, 90–91).

Section 1008 of Title X precludes grants from being "used in programs where abortion is a method of family planning." 42 U.S.C. § 300a-6. Grantees are subject to rigorous audit and compliance programs to ensure that Title X funds are not used for any such prohibited activities. (ER190).

---

[1] SSER refers to plaintiff States' supplemental excerpt of record and PSER refers to AMA/Planned Parenthood's supplemental excerpts.

[2] HHS, Office of Population Affairs, *Funding History*, https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/funding-history/index.html (last accessed 5/20/2019).

2. The 1981 Guidelines

For nearly fifty years, HHS has recognized that § 1008 allows Title X projects to provide the nondirective pregnancy counseling required by established standards of medical care and medical ethics. *See* 65 Fed. Reg. 41,270, 41,273–74 (2000).[3] These standards require the provision of information about prenatal care and delivery, adoption, and abortion in a neutral manner that does not steer the patient toward a particular option. *See* American Academy of Pediatrics, Committee on Adolescence, Options Counseling for the Pregnant Adolescent Patient ("AAOP Counseling"), Pediatrics Vol. 140(3), at 2–3 (2017).[4] The information provided during nondirective counseling includes

[3] *See* U.S. Dep't of Health & Human Services, Health Resources & Services Administration, *Report to Congress: The Infant Adoption Awareness Training Program* 4 (Nov. 2002) (review "revealed that every professional practice standard…specified non-directive counseling as part of the professional standard of care"); *id.* at 10–11 (collecting standards).

[4] American Academy of Pediatrics, Committee on Adolescence, Counseling the Adolescent About Pregnancy Options, Pediatrics Vol. 83(1), at 135–37 (1989); American Medical Association (AMA) Comment 2; American College of Obstetricians & Gynecologists (ACOG) Comment 6; American Academy of Nursing Comment 4.

Plaintiff States have included the pertinent comment letters in the addendum.

both "an unbiased discussion" of pregnancy options and referrals "to appropriate resources and services." AAOP Counseling 2017, *supra*, at 1.[5]

In 1981, HHS issued written guidelines requiring all Title X grantees to offer nondirective counseling, including referrals, to pregnant patients. U.S. Department of Health & Human Services, Program Guidelines for Project Grants for Family Planning Services (1981) ("1981 Guidelines") (States' Add. 12). As HHS explained at the time, nondirective counseling comports with § 1008 because evenhanded discussion of all legal pregnancy options does not fund abortions or promote abortion as a method of family planning.[6] *See National Family Planning & Reproductive Health Assoc., Inc. v. Sullivan* ("*NFPRHA*"), 979 F.2d 227, 229 (D.C. Cir. 1992).

3. The 1988 Regulations

In 1988, HHS reversed course and prohibited Title X projects from providing any counseling about abortion, including referrals. 53 Fed. Reg. 2922, 2954 (1988). The 1988 regulations further required that all Title X programs be physically and financially separated from any abortion-related

[5] *See also* ER28 (AMA code of ethics requires physicians to "cooperate in coordinating medically indicated care with other health care professionals").

[6] Although the text of §1008 does not prohibit Title X funds from being used to "promote" abortion, HHS has interpreted it to have that meaning based on the remarks of one of the sponsors of Title X. *See* 65 Fed. Reg. at 41,272; 116 Cong. Rec. 37,375 (1970) (remarks of Rep. Dingell).

activities. *Id.* at 2945. In promulgating the physical-separation requirement, HHS primarily relied on reports from the United States General Accounting Office (now the Government Accountability Office) and HHS's Office of Inspector General, which HHS claimed expressed concerns about potential confusion among Title X grantees about how to comply with § 1008. *Id.* at 2923–24.

The Supreme Court upheld the 1988 regulations in *Rust v. Sullivan*, 500 U.S. 173 (1991), concluding that § 1008 was ambiguous because Congress had not spoken "directly to the issues of counseling, referral, advocacy, or program integrity." *Id.* at 184. The Court also concluded that the regulations were sufficiently supported by the administrative record presented then. *Id.* at 187–89. Because of additional litigation, the regulations never went fully into effect. *See NFPRHA*, 979 F.2d at 241.

In 1993, HHS revoked the 1988 regulations, reinstated the 1981 Guidelines, and removed the physical-separation requirements. 58 Fed. Reg. 7464, 7465–66 (1993).

4. Congress's Mandate That All Pregnancy Counseling in Title X Be Nondirective (the Nondirective Mandate)

Starting in 1996, Congress enacted appropriations statutes every year requiring that "all pregnancy counseling" in Title X programs "shall be

nondirective" (the Nondirective Mandate).[7] The legislative history and context of the Nondirective Mandate make clear that Congress intended nondirective pregnancy counseling to have the meaning reflected in prevailing medical standards of care and adopted by the 1981 Guidelines.

After *Rust*, Congress twice passed legislation—ultimately vetoed—clarifying that § 1008 had always permitted nondirective counseling, including referrals, about all legal pregnancy options.[8] As both supporters and opponents of these and similar bills explained, nondirective counseling means providing factual information about all pregnancy options without steering a patient to "one option over another." 137 Cong Rec. 18,435 (1991) (Senator Chafee, sponsor of S. 323); *id.* at 18,491 (Senator Hatch, who opposed S. 323, explaining that "truly nondirective" counseling would not "counsel for one option over another"). And as legislators and advocates further explained,

---

[7] Department of Health and Human Services Appropriations Act, 1996, Pub L. No. 104-134, 110 Stat. 1321-221 (1996); *see also*, *e.g.*, Department of Health and Human Services Appropriations Act, 2019, Pub. L. No. 115-245, 132 Stat. 2981, 3070–71 (2018).

[8] *See* H.R. 2707, 102d Cong., § 514 (1992) (reported in Senate) (prohibiting HHS from using funds to implement 1988 counseling-related regulations); S. 323, 102nd Cong. (1992) (enrolled bill) (requiring Title X programs to provide "information regarding pregnancy management options," meaning "nondirective counseling and referrals" about prenatal care and delivery, adoption, and abortion).

nondirective counseling includes referrals—as the 1981 Guidelines had previously required. *See* H.R. Rep. 102-204 (1991) (1981 Guidelines "enumerated such [nondirective] options counseling to include information and referral").[9]

Congress applied this same understanding of nondirective pregnancy counseling in the Nondirective Mandate. Congress enacted the Mandate to preserve then-current "law and policy with respect to title X recipients and abortion funding, counseling, and lobbying." 141 Cong. Rec. H8252 (Aug. 2, 1995); *see id.* at H8250 (Representative Greenwood explaining that the appropriations "amendment restores the Title X planning program"). The appropriations statute reiterated § 1008's requirement that Title X funds "shall not be expended for abortions." *Id.* at H8249. And consistent with the 1981 Guidelines—which were then back in place—the appropriations statute made "clear that all counseling must be nondirective," i.e., all counseling must "lay out the legal options" available to pregnant patients. *Id.* at H8250.

[9] *See, e.g., Title X Regulations (The Gag Rule): Health Implications for Poor Women, Hr'g of the S. Comm. on Labor & Human Resources* 34 (May 16, 1991) ("*The Gag Rule*") (statement of Lee Minto, Planned Parenthood of Seattle-King County) (nondirective counseling insures that a patient "receives accurate information" and "gets appropriate referrals").

In 2000, HHS promulgated regulations implementing the Nondirective Mandate and formally adopting the nondirective counseling rules set forth in the 1981 Guidelines. 65 Fed. Reg. at 41,270–01. The 2000 regulations also provide that while grantees must financially separate their Title X programs from abortion-related serviced funded by non-Title X funds, physical separation is not required. *Id.* at 41,275–76. HHS explained that even without a physical-separation requirement, Title X grantees had been successfully separating their Title X and abortion-related services "for virtually the entire history" of Title X. *Id.* at 41,275.

5. The Affordable Care Act (ACA)

In 2010, Congress enacted § 1554 of the ACA to further protect patients' ability to receive medical information and services that are ethically and medically necessary. Section 1554 broadly prohibits HHS from promulgating "any regulation" that creates "unreasonable barriers" to obtaining appropriate medical care; impedes "timely access" to such care; interferes with patient-provider communications "regarding a full range of treatment options"; restricts providers from disclosing "all relevant information to patients making health care decisions"; or violates providers' ethical standards. 42 U.S.C. § 18114.

B. The Final Rule

In March 2019, HHS published the Final Rule at issue here. Despite the Nondirective Mandate, the Final Rule allows Title X grantees to give patients *directive* pregnancy counseling that discusses prenatal care and adoption while entirely omitting any information about abortion. 84 Fed. Reg. 7714, 7724, 7733, 7744–46 (2019). The Final Rule also places asymmetric burdens on abortion-related information—for example, by requiring that any counseling about abortion include counseling about another pregnancy option—regardless of the patient's wishes. *Id.* at 7747. The Rule also requires providers to refer every pregnant patient for prenatal care and prohibits providers from giving any referrals for abortion—regardless of what the patient wants. *Id.* at 7744–49, 7789–90.

The Final Rule further requires Title X-funded care to be physically separated from activities prohibited by the Final Rule, including referrals for abortion: i.e., entirely separate facilities, separate personnel and workstations, and separate healthcare records. *Id.*

C. Procedural Background

Immediately after HHS adopted the Final Rule, plaintiffs here—20 States and the District of Columbia—challenged the Final Rule as contrary to the Nondirective Mandate, contrary to § 1554, and arbitrary and capricious.

Plaintiffs then moved for a preliminary injunction, as did a group of individual medical providers and organizations of medical providers who sued in a consolidated case.

1. The Preliminary Injunction

The district court preliminarily enjoined the Rule's implementation.[10] The court first determined that plaintiffs are likely to succeed on the merits of their APA claims. The court concluded that the Final Rule likely contravenes Congress's Nondirective Mandate by, for example, requiring referrals for prenatal care while prohibiting referrals for abortion. The court rejected defendants' contention that the Nondirective Mandate does not encompass referrals, explaining that "common sense, the agency's own guidance, and Congress's statutory language indicate" that counseling includes referrals. (ER18–19). The court also determined that the physical-separation requirements likely violate § 1554 by disrupting Title X programs and creating unreasonable barriers to healthcare. (ER26–27).

[10] Three other district courts have also preliminarily enjoined the Final Rule. *See Washington v. Azar*, 2019 WL 1868362, at *9 (E.D. Wash. Apr. 25, 2019); *California v. Azar*, 2019 WL 1877392, at *44 (N.D. Cal. Apr. 26, 2019); *Mayor and City Council of Baltimore v. Azar*, 2019 WL 2298808, at *13 (D. Md. May 30, 2019).

Regarding the likely irrationality of the Rule, the court explained that the Rule requires Title X providers to violate established standards of medical care and ethics, and that HHS's contrary assertions lacked any evidentiary support or rational explanation. (ER27–31). The court also concluded that HHS had arbitrarily failed to consider the enormous costs and public-health harms that will result from the Final Rule, including harms to low-income women who already face barriers to obtaining care. (ER31–34).

The district court next found that the plaintiff States, their residents, and the public health would be irreparably harmed absent a preliminary injunction. (ER32–34). The court explained that by forcing state and private grantees to violate established standards of medical care and ethics, the Rule will compel most existing grantees to exit the Title X program. (ER33). That will devastate Title X and will reduce access to healthcare and family-planning services, decrease testing for sexually transmitted infections and cancer, and increase unintended pregnancies and abortions—imposing significant costs on the States and harming the health of their most vulnerable residents. (ER33).

Finally, the court determined that defendants would not suffer any irreparable harm from maintaining the status quo pending judicial review. The court emphasized that the current regulations' requirements for nondirective counseling and financial (but not physical) separation of Title X funds have

governed the Title X program "for nearly 50 years and have an excellent track record." (ER34).

2. The Motions Panel Stay Opinion

On June 20, 2019, based on limited expedited briefing and without any oral argument, a motions panel of this Court (Leavy, Callahan, Bea, JJ.) issued a published opinion granting defendants' motion to stay the preliminary injunction, thereby allowing HHS to implement the Final Rule immediately. Plaintiff States filed an emergency motion seeking en banc reconsideration of the stay order, as did the plaintiffs in several other cases covered by the motions panel's stay order. Those motions were pending when this brief was filed.

SUMMARY OF ARGUMENT

The district court properly exercised its discretion in issuing a preliminary injunction to preserve the status quo pending judicial review of the Final Rule.

A. The district court correctly concluded that plaintiffs are likely to prevail on the merits.

1. The Final Rule is likely contrary to an appropriations statute mandating that all Title X pregnancy counseling be nondirective (the Nondirective Mandate) and to § 1554 of the Affordable Care Act (ACA). In contravention of the Mandate, the Rule allows grantees to offer *directive*

counseling that discusses only prenatal care and adoption while omitting any information about abortion. The Rule also imposes asymmetric burdens on abortion-related information, including by prohibiting any abortion referrals. For substantially these same reasons, the Final Rule likely violates § 1554 of the ACA too—interfering with patient-provider communications regarding treatment, and forcing violations of medical ethics. As the district court correctly determined, the Rule will severely impede patient access to healthcare as well by forcing many providers to withdraw from Title X. Plaintiffs and other commenters raised each substantive way in which the Rule violates § 1554, and thus fully preserved their arguments regarding that provision.

Rust v. Sullivan does not control here because the Nondirective Mandate and the ACA were enacted after *Rust*. Those statutes eliminate the ambiguity that *Rust* found in § 1008 of Title X, which precludes grants from being "used in programs where abortion is a method of family planning." They do not overrule § 1008, but rather restrict what HHS may do in the name of enforcing § 1008.

2. The Final Rule likely is arbitrary and capricious because HHS did not adequately consider and address the significant harms it would inflict on the Title X program and public health. The administrative record shows that the Rule's requirement to provide counseling that violates medical ethics, and its

requirement to maintain physically separate facilities and personnel for any non-Title X abortion-related activities (including giving abortion referrals), will force many providers to leave the program, and that as a result many providers would leave the program. Yet HHS concluded, without support, that the rule would have no significant impact on access to Title X's essential healthcare services.

B. The district court properly exercised its discretion in finding that the balance of harms and public interest weigh heavily in favor of preliminarily enjoining the Rule. As the court found based on plaintiffs' unrebutted evidence, the Rule's forcing out of most existing Title X providers will reduce access to vital family-planning and healthcare services for vulnerable patients who have low incomes or live in rural communities. The result will be more unintended pregnancies, more abortions, less cancer detection, and less testing for sexually transmitted diseases. The plaintiff States will be irreparably harmed by the resulting damage to public health within their borders; and they will incur unrecoverable costs while coping with the gaps in care and negative health outcomes caused by the Final Rule.

By contrast, HHS will not suffer any irreparable harm from maintaining the status quo that has governed Title X for nearly fifty years. Indeed, defendants' claims of harm were generic, speculative, and unsupported.

C. The district court also properly exercised its discretion in issuing a preliminary injunction that essentially postpones the effective date of the Final Rule—an interim remedy that the APA expressly authorizes when necessary to prevent irreparable injury. And the same equities that make it appropriate to enjoin the Rule as to the plaintiff States also make it appropriate for the preliminary relief to extend nationwide and to nonparties.

ARGUMENT

THE PRELIMINARY INJUNCTION PROPERLY PRESERVES THE STATUS QUO

A preliminary injunction is a matter of equitable discretion. *California v. Azar*, 911 F.3d 558, 575 (9th Cir. 2018). The party seeking an injunction must show that "(1) it is likely to succeed on the merits, (2) it is likely to suffer irreparable harm in the absence of preliminary relief, (3) the balance of equities tips in its favor, and (4) an injunction is in the public interest. *Id.* at 568. Here, the district court properly exercised its discretion in granting a preliminary injunction, because plaintiffs demonstrated that all four factors weighed strongly in their favor.[11]

[11] The motion panel's opinion does not control the issues presented here. The question for the motions panel was whether to grant a temporary stay until a merits panel could rule. And the motions panel could make only a preliminary *prediction*, based on limited briefing and without oral argument, about how the appeal will turn out. This merits panel, by contrast, is being asked to rule

Footnote continued…

A. The States Are Likely to Succeed on the Merits

1. The Final Rule is likely contrary to law.

The district court correctly concluded that the Final Rule is likely contrary to Congress's mandate that "all pregnancy counseling" in Title X projects "shall be nondirective," 132 Stat. at 3070-71, and to § 1554 of the Affordable Care Act. (ER18–32); *see also California*, 2019 WL 1877392, at *14–26; *Washington*, 2019 WL 1868362, at *7–9; *Baltimore*, 2019 WL 2298808, at *8-11. These statutes were enacted after the Supreme Court's decision in *Rust v. Sullivan*, and thus *Rust* does not address their constraints on HHS.

a. The Final Rule likely violates Congress's mandate that "all pregnancy counseling" in Title X be "nondirective."

Under long-settled standards of medical care and ethics, nondirective pregnancy counseling requires the neutral presentation of all legal pregnancy

---

(…continued)
definitively on the question presented, on full briefing and with the benefit of argument if the panel permits.

Lair v. Bullock, 798 F.3d 736 (9th Cir. 2015), is not to the contrary. *Lair* noted that a motions panel can issue published decisions that constitute binding Ninth Circuit precedent. *Id.* at 747. But the only holding from the motions panel that the *Lair* Court treated as binding was one that had already been established by another binding three-judge panel opinion. *See id. Lair* thus had no occasion to consider the question presented here, which is whether there is a difference between a prediction of success on appeal and actual success after full briefing and argument.

options about which the patient inquires, with referrals on request. See *supra*, at 4–9. The Final Rule violates this Nondirective Mandate by (i) allowing providers to omit all information about abortion; (ii) requiring providers that discuss abortion to omit certain abortion-related information and to force patients to receive information about non-abortion options they do not want; and (iii) prohibiting providers from referring patients for abortion while requiring providers to refer every pregnant patient for prenatal care.

(i) Omitting Abortion Information: The Final Rule allows Title X providers to steer a patient towards prenatal care and adoption by discussing only those options while omitting all information about abortion, giving a list of primary care providers that do not offer abortions, and supplying referrals only for prenatal care and adoption agencies—even if the patient has specifically requested abortion-related information. *See* 84 Fed. Reg. at 7789; *id* at 7745 ("Title X projects will not be required to offer nondirective pregnancy counseling in general, *or abortion information and counseling specifically*." (emphasis added)). As the motions panel recognized, the Final Rule states that Title X providers "*may* include neutrally-presented information abortion" (Op. 18 (emphasis added)), but does not require that. And as defendants' acknowledge (Br. 19), providers are permitted but not required to disclose that they are actively withholding abortion-related information.

But "removing an option from the client's consideration necessarily steers her toward the options presented and is a directive form of counseling" that plainly contravenes the Nondirective Mandate. 65 Fed. Reg. at 41,274; *see, e.g.*, 137 Cong. Rec. 18,453 (counseling impermissibly directive if provider "does not have to give" information about abortion). Mistakenly regarding counseling as nondirective even if it omits any information about abortion, the motions panel erroneously accepted that the Final Rule requires that "such counseling as is given shall be nondirective" (Op. 18). *See* 84 Fed. Reg. at 7716 (stating that Final Rule "permits the use of Title X funds in programs that provide pregnancy counseling, so long as it is nondirective"). But the failure of the Final Rule to require that all Title X counseling is in fact nondirective is fatal to the Rule because Congress required that "*all* pregnancy counseling" in the Title X program must be nondirective.. This broad mandate does not authorize HHS to allow directive pregnancy counseling, as HHS recognized in its 2000 regulations. *See* 65 Fed. Reg. at 41,273.

(ii) Asymmetrical Burdens on Abortion Information: The Final Rule forces providers that include abortion-related information in counseling to give patients information about pregnancy options that the patients do not want—and prevents patients from receiving abortion-related information that they do want. For example, the Final Rule prohibits a provider from counseling a

patient about abortion without also counseling the patient about at least one other pregnancy option—regardless of the patients' wishes. *See* 84 Fed. Reg. at 7747. By contrast, a patient who wants information about only prenatal care or adoption may receive that information alone. Moreover, a patient who wants to learn about only abortion must nonetheless receive "information about maintaining the health of the mother and unborn child during pregnancy." *Id.* And such a patient may receive a list of "comprehensive primary health care providers," but more than half of those providers cannot offer abortion and none of those providers can be identified as offering abortion. *Id.* at 7789.

Steering patients away from abortion in this manner violates the Nondirective Mandate. The motions panel adopted defendants' argument (Br. 24, 28) that requiring clinics to present information in a selective way comports with the Nondirective Mandate so long as the provider does not "affirmatively endorse one option over another" (Op. 19). But requiring clinics to provide information on some options but not others *is* directive counseling. *See, e.g.*, *Gag Rule*, *supra*, at 3 ("requiring clinics to provide information on some options but not others" impermissibly skews patient decision making).

Equal presentation of all options about which the patient wants to learn is fundamental to nondirective counseling. Otherwise, a provider could impermissibly favor one option over another simply by presenting selective

information. *See* 138 Cong. Rec. H2826 (Apr. 30, 1992) (nondirective counseling means "not suggesting or advising one option over another"). Congress could not plausibly have allowed providers to evade the Nondirective Mandate so easily. As HHS recognized in the Final Rule, counseling in which providers give information about only abortion, or in which providers conceal which primary care providers offered prenatal care, would be impermissibly directive. *See* 84 Fed. Reg. at 7716. The same weighting of information against abortion and in favor of other options likewise contravenes the Nondirective Mandate's broad requirement that "all pregnancy counseling" in Title X programs "shall be nondirective." 132 Stat. at 3070–71.

Contrary to defendants' arguments, a statutory provision known as the Infant Adoption Awareness Act (IAAA) further demonstrates that Congress understood nondirective counseling to require the equal treatment of pregnancy options. The IAAA created a program to train Title X and other providers "in providing adoption information and referrals to pregnant women on an equal basis with all other courses of action included in nondirective counseling to pregnant women." 42 U.S.C. § 254c-6(a)(1). Congress's use of the word "equal" did not establish an equal-treatment requirement for adoption that was previously absent. Rather, Congress allocated resources for a training program to ensure that providers were able to satisfy the Nondirective Mandate's

preexisting requirement to treat adoption and all other legal pregnancy options equally during counseling. *See, e.g.*, 146 Cong. Rec. H2718 (May 9, 2000). The motions panel was thus incorrect in asserting that plaintiffs' interpretation of the Nondirective Mandate strips the IAAA of meaning (Op. 19).

(iii) Directive Referrals: The Final Rule further violates the Nondirective Mandate by requiring Title X providers to refer *every* pregnant patient for prenatal care and prohibiting providers from referring *any* pregnant patient for an abortion, regardless of the patients' wishes. 84 Fed. Reg. at 7788–89.

Defendants incorrectly assert that nondirective counseling excludes referrals. (Br. 24–28). Referrals—i.e., giving the names, locations, and contact information of providers of postconception services—have long been an integral part of the factual information provided during pregnancy counseling, as Congress well understood when enacting the Nondirective Mandate.

Each year that Congress enacted the Nondirective Mandate, established standards of medical care and ethics required that nondirective counseling include referrals See *supra* at 6–9. In the 1981 Guidelines, HHS formally applied this settled medical understanding. Specifically, in a section entitled "Pregnancy Diagnosis and Counseling," the 1981 Guidelines directed Title X providers to offer pregnant patients "information and counseling regarding their pregnancies," including nondirective counseling "*and referral upon request*."

Id. at 12–13 (emphasis added). HHS again set forth this understanding of nondirective counseling in the 2000 regulations. *See* 65 Fed. Reg. at 41,274, 41,279. Defendant Office of Population Affairs, a subdivision of HHS, continues to require grantees to follow established medical standards in conducting nondirective counseling, emphasizing that "[r]eferral to appropriate providers of follow-up care should be made" for pregnant patients.[12] And Congress has repeatedly recognized in other statutes that medical and other professional counseling includes referrals.[13]

Congress was well aware of the settled understanding that nondirective counseling includes referrals, and of HHS's position, when it enacted the Nondirective Mandate. After *Rust*, Congress debated statutes that would have reinstated the 1981 Guidelines. See *supra*, at 7–8. During this time period, a

---

[12] Loretta Gavin, Susan Moskosky, et al., Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs, Morbidity and Mortality Weekly Report, 63 Recommendations and Reports No. 4, 14 (April 25, 2014) ("QFP"); *see also id.* at 4, 13.

[13] *See* 42 U.S.C. § 300ff-33(g)(1)(B)(ii) ("post-test counseling (including referrals for care)" provided to individuals with positive HIV/AIDS test); 38 U.S.C. § 1720D(b)(2) (counseling for sexual-trauma treatment includes "referral services"); 42 U.S.C. § 3020e-1(b) (pension counseling includes "information, counseling, referral, and other assistance"); 20 U.S.C. § 1161k(c)(4)(A) (college counseling includes "referrals to and follow-up with other student services staff").

Senate Report observed that counseling in Title X program should follow "medical and professional ethics of the American Medical Association and the American College of Obstetricians and Gynecologists." S. Rep. 102-86 (1991). Senators made the same observations on the Senate floor. *See, e.g.*, 137 Cong Rec. at 18,439 (Senator Packwood) (Title X program should give "quality and type of counseling" that "organizations such as the American Medical Association state in their guidelines that physicians should give"). And legislators, representatives of medical associations, and advocates made clear that referrals fell within the settled meaning of nondirective counseling adopted by both medical standards of care and the 1981 Guidelines. *See e.g.*, H.R. Rep. 102-240 (1991) (1981 Guidelines required "nondirective options counseling" and "enumerated such options counseling to include information and referral").[14]

Although these bills were vetoed or otherwise not enacted, Congress later adopted the same settled meaning of nondirective pregnancy counseling when it

---

[14] *See also 1991 Reauthorization Hr'g*, at 10 (Representative Porter) (during nondirective counseling, "[h]onest information is given, referral provided"); 137 Cong Rec. at 18,453 (failing to provide referrals for abortion does not ensure that each patient "receives nondirective counseling"); *id.* at 18,435 (directive counseling includes requiring referral "only for prenatal care," prohibiting referrals for abortion, and providing "list of providers that promote the welfare of the mothers and unborn child").

imposed the Nondirective Mandate.[15] In response to efforts to defund Title X, Congress adopted the Nondirective Mandate to preserve the program and the then-existing "law and policy" about "abortion funding, counseling, and lobbying," 141 Cong. Rec. at H8252. At that time, existing law and policy—including the 1981 Guidelines then in place—required all Title X providers to offer referrals as part of nondirective pregnancy counseling. The Nondirective Mandate should be read to incorporate that established understanding of HHS and the medical community. *See McDermott Int'l, Inc. v. Wilander*, 498 U.S. 337, 342 (1991) (courts "assume that when a statute uses [a term of art], Congress intended it to have its established meaning").

Defendants misread HHS's prior rules as having treated referrals as separate from counseling, based on HHS's reference in those rules to both nondirective counseling "and" referrals. (*See* Br. 26–27). But read in context,

---

[15] Defendants misplace their reliance (Br. 25–26) on the text of one of the unenacted bills, the Family Planning Amendment Acts of 1992. Consistent with the approach in HHS' 1981 guidelines, that bill treated "information" and "referrals" as elements of pregnancy counseling by requiring Title X providers to offer "nondirective counseling *and* referrals." *See* S. 323, 102nd Cong. § 2 (1992). The bill's drafters did so to specifically address (and overrule) the 1988 regulations in effect at the time, which separately prohibited *both* nondirective counseling and referrals. 53 Fed. Reg. at 2928, 2936. Congress did not need to include any similar specification concerning referrals when enacting the Nondirective Mandate in 1996, because HHS had by that time returned to the long-settled understanding that nondirective counseling includes referrals. *See California*, 2019 WL 1877392, at *17–18.

the word "and" specified that a referral, like the provision of factual information, is one of several pieces of the counseling process—in keeping with the medical establishment's understanding. Indeed, the 2000 regulations specified that counseling includes "factual information *and* nondirective counseling . . . *and* referral." 65 Fed. Reg. at 41,279. Defendants do not dispute that this regulation treated factual information about pregnancy options as part of nondirective counseling, notwithstanding the regulation's use of the term "and" between "factual information" and "nondirective counseling." The regulation likewise treated referrals as part of nondirective counseling, notwithstanding its use of the term "and" between "nondirective counseling" and "referrals."

Congress again expressed its understanding that nondirective counseling includes referrals when it enacted the IAAA as an amendment to the Public Health Service Act—the same law that contains Title X. The IAAA funded training "in providing adoption information and referrals to pregnant women on an equal basis with all other courses of action included in nondirective counseling to pregnant women." 42 U.S.C. § 254c-6(a)(1). Both Congress and HHS made clear that the IAAA ensures staff will be trained to include "adoption information and referrals" in nondirective counseling on an equal basis with the nondirective counseling provided about other options. For

example, legislators explained that "the [IAAA] refers to pregnancy counselors providing adoption information and referrals as a part of pregnancy counseling." 146 Cong. Rec. at H2719. In assessing whether the IAAA was fulfilling its purpose "to promote training for presenting the option of infant adoption as part of a course of non-directive counseling," HHS evaluated "the extent to which adoption information and referral, upon request," were being provided. *Report to Congress*, *supra*, at 2. And in the Final Rule here, HHS reaffirmed that the IAAA expressed Congress's "intent that postconception adoption information and referrals be included as part of any nondirective counseling in Title X projects." 84 Fed. Reg. at 7730.[16]

Defendants' interpretation of § 254c-6(a)(1) to exclude the provision of "information and referrals" from "nondirective counseling" (Br. 27) contradicts the settled "presumption that a given term [i.e., nondirective counseling] is used to mean the same thing throughout a statute." *Brown v. Gardner*, 513 U.S. 115, 118 (1994).

Defendants' bald assertion that neither Congress nor HHS understood nondirective counseling to include referrals is further belied by the Final Rule,

---

[16] *See also* 84 Fed. Reg. at 7744 (grantees "may provide adoption information and referrals" during postconception nondirective counseling because IAAA specified that Title X clinics "should receive training on providing adoption information and referrals").

in which HHS repeatedly "includes referrals within pregnancy counseling." (ER18). As the district court correctly observed, the Rule states that "Title X projects should not use nondirective pregnancy counseling, *or referrals* made for prenatal care or adoption *during such counseling*" to encourage or promote abortion as a method of family planning. 84 Fed. Reg. at 7747 (emphasis added). And it states that "nondirective pregnancy *counseling can include* counseling on adoption, and corresponding *referrals* to adoption agencies." *Id.* at 7730 (emphasis added). These statements do not remotely suggest that referrals are "something that merely may occur at the same time as counseling" (Br. 27–28), particularly given that HHS specified that "counseling, information, and referral" are "*part of* nondirective postconception counseling," 84 Fed. Reg. at 7733–34. Nor can these statements plausibly be dismissed as "preamble" (Br. 27) when HHS reiterated that nondirective counseling includes referrals throughout critical portions of the Final Rule explaining counseling.

Providing referrals for postconception services is particularly important for nondirective counseling in the context of Title X, because, as defendants emphasize (Br. 1, 38), Title X does not fund *any* postconception care. Thus, for a Title X provider, the fundamental purpose of nondirective counseling is to enable pregnant patients to make their own well-informed decisions about postconception care outside of the Title X program—whether that entails

prenatal, adoption, or abortion services. *See* 84 Fed. Reg. at 7716 (Final Rule explaining that nondirective counseling must "empower the client to be informed" about all postconception options). Denying a patient information about abortion services while forcing her to receive information about prenatal services impermissibly controls the "information she needs to make her own decision." 137 Cong. Rec. at 18,493; *see also id.* at 18,435 (Senator Chafee) (requiring referrals for prenatal care while prohibiting referrals for abortion "is not nondirective counseling" and is instead "forcing a woman to choose a particular option"). Title X's "limited" focus on preconception family-planning services (Br. 1) thus reinforces the importance of even-handed referrals for all postconception options during nondirective counseling. It does not provide any basis to treat postconception referrals as separate from counseling, or to prohibit referrals for only one postconception option (abortion) while requiring referrals for another postconception option (prenatal services).

b. The Final Rule's separation requirements and the counseling requirements likely violate § 1554 of the ACA

i. The Final Rule likely violates § 1554

As the district court properly concluded (ER23–26), the Final Rule's separation requirements and counseling requirements likely contravene § 1554 of the ACA, which broadly prohibits HHS from issuing "any regulation" that creates "unreasonable barriers" to medical care; impedes "timely access" to

such care; interferes with patient-provider communications "regarding a full range of treatment options"; restricts providers from giving "full disclosure of all relevant information to patients making health care decisions"; or violates healthcare providers' ethical standards. 42 U.S.C. § 18114. The separation requirements will force any provider that engages in abortion-related activities with non-Title X funds—including providers that simply refer patients for abortion as part of truly nondirective counseling—to maintain separate facilities, separate personnel and workstations, and separate healthcare records for such activities. And the counseling requirements interfere with patient-provider communications and require violations of ethical standards. *See, e.g.*, ACOG Comment 6 (physicians have an ethical obligation to "provide a pregnant woman who may be ambivalent about her pregnancy full information about all options in a balanced manner").

As many commenters warned, the physical separation requirements and counseling requirements will force many Title X providers to exit the program, thereby decimating States' Title X networks. This exodus of providers will severely impede patients' access to critical family-planning and health-care services. *See infra* at 40–45. Most Title X patients have low incomes, lack health insurance, and live in rural communities or face other substantial hurdles to accessing quality and timely healthcare. Such patients already have few

options and often rely on "Title X providers [as] their only ongoing source of health care and health education." HHS, Office of Population Affairs, Title X Family Planning Annual Report, 2016 National Summary, at ES-1 (Aug. 2017). The disruption caused by the separation and counseling requirements will thus impede access to care for many of the country's most vulnerable patients.

Defendants do not dispute that the Final Rule's limitations on nondirective counseling—including the prohibition against referrals for abortion and the rules about lists of primary care physicians—restrict grantees ability to communicate with patients and provide relevant information about pregnancy options. *See California*, 2019 WL 1877392, at *24. HHS asserted in the Final Rule that such information-sharing restrictions were appropriate because "[i]nformation about abortion and abortion providers is widely available and easily accessible, including on the internet." 84 Fed. Reg. at 7746. But blocking patients from receiving information from trusted medical professionals on the ground that patients can search the internet instead is precisely the type of interference with provider-patient communications that § 1554 prohibits.

Indeed, pregnant patients who are given directive counseling or referrals that omit abortion may have little reason to conduct their own internet research unless the Title X provider discloses that it has omitted abortion as an option—a

disclosure that the Final Rule does not require. *See* 84 Fed. Reg. at 7716. Instead, the patient will likely begin making appointments and visiting the providers to which she was referred. Such impediments to timely healthcare are particularly problematic because patients often must obtain an abortion quickly or lose their opportunity to do so.

ii. Plaintiffs did not waive their § 1554 claim.

The motions panel incorrectly accepted defendants' assertion (Br. 33–34) that plaintiffs waived their ACA challenge by not citing § 1554 by name during notice and comment. As an initial matter, the waiver doctrine is inapplicable where, as here, an agency's rulemaking is outside the scope of its statutory authority. *See Sierra Club v. Pruitt*, 293 F. Supp. 3d 1050, 1061 (N.D. Ca. 2018). The waiver doctrine ensures that an agency has a fair opportunity to "apply its expertise, to correct its own errors, and to create a record for" appellate review. *Portland Gen. Elec. Co. v. Bonneville Power Admin.*, 501 F.3d 1009, 1024 (9th Cir. 2007). But determining whether HHS has acted ultra vires falls squarely within the expertise of the courts rather than the agency—particularly when defendants do not contend that there is any ambiguity in § 1554. *See United States v. Able Time, Inc.*, 545 F.3d 824, 835–36 (9th Cir. 2008). The judicially created waiver doctrine thus does not give HHS license to maintain an ultra vires regulation that is plainly contrary to law.

In any event, commenters raised the "specific argument[s]" raised by plaintiffs here, *Koretoff v. Vilsack*, 707 F.3d 394, 398 (D.C. Cir. 2013) (per curiam), by identifying each substantive way in which the Final Rule contradicts § 1554.[17] For example, commenters emphasized that the Final Rule will "create barriers to access to women's healthcare," California Attorney General et al., Comment at 4 (July 30, 2018); "harm patients by reducing access to care" for time-sensitive procedures like abortion, New York Attorney General, Comment at 8, 11 (July 31, 2018); restrict "the provision of information on reproductive health and abortion," *id.* at 11; and force providers "to violate their ethical obligations," California Medical Association, Comment 4 (July 31, 2018). Indeed, HHS acknowledged comments "objecting that the Final Rule created barriers to patients' access to care, interfered with provider-patient communications, and violated principles of medical ethics." *California*, 2019 WL 1877392, at *21. HHS thus had ample "opportunity to consider the issue[s]." *Portland Gen.*, 501 F.3d at 1024; *see also Native Ecosystems Council*

[17] In *Koretoff*, no commenter had raised the underlying substantive issue of whether the agency had properly required treatment of food products "irrespective of whether they [were] contaminated." 707 F.3d at 398. Here, by contrast, commenters specifically raised each of the issues underlying whether HHS violated § 1554.

v. Dombeck, 304 F.3d 886, 899 (9th Cir. 2002) (no waiver where "administrative decisionmaker understood plaintiffs to raise the issue").

This is especially so because HHS was fully aware of § 1554 and that provision's relevance to regulatory provisions impeding access to contraception and abortion. Before HHS issued the Final Rule, it had already analyzed whether § 1554 was violated by a regulation allowing insurance plans to refuse to cover contraceptive care based on religious or moral objections—a regulation that is directly connected to the Final Rule's redefinition of "low income family" to include women whose insurance plans invoked such objections. *See* 83 Fed. Reg. 57,546, 57,551–52 (2018); 84 Fed. Reg. at 7734–39, 7787. Given that HHS was on notice of § 1554 and the substantive ways in which the Final Rule likely violates § 1554, defendants' argument boils down to the contention that commenters waived their § 1554 contrary-to-law argument by failing to cite that statute specifically. But this Court has already rejected such a formalistic approach, making clear that commenters "need not raise an issue using precise legal formulations" and that "alerting the agency in general terms will be enough." *Lands Council v. McNair*, 629 F.3d 1070, 1076 (9th Cir. 2010); *see also, e.g.*, *Idaho Sporting Cong., Inc. v. Rittenhouse*, 305 F.3d 957, 966 (9th Cir. 2002) (no waiver where commenters "expressed concern" without citing regulation).

iii. Defendants' other arguments are meritless

There also is no merit to defendants' other objections to § 1554's applicability here. First, defendants contend (Br. 35–36) that § 1554 applies to regulations issued under only the ACA and not to regulations issued under Title X. But by its plain terms, § 1554 broadly precludes HHS from promulgating "*any* regulation" that contravenes § 1554's terms. 42 U.S.C. § 18114 (emphasis added). By contrast, where Congress wanted a provision to apply to actions taken under only the ACA, it said so expressly. *See*, *e.g.*, 42 U.S.C. § 18112 (directing HHS to publicly list all "authorities provided to the Secretary under this Act"); *id.* § 18113 (prohibiting providers that receive "Federal financial assistance under this Act" from engaging in certain discrimination). Congress thus knew "how to limit" the ACA's application but declined to limit § 1554's reach. *See Miller v. Clinton*, 687 F.3d 1332, 1340 (D.C. Cir. 2012).

Defendants are incorrect that Congress limited § 1554 by using the prefatory phrase "[n]otwithstanding any other provision of this Act," 42 U.S.C. § 18114. This prefatory clause means that HHS "cannot engage in the type of rulemaking proscribed," i.e., issue any regulation that violates § 1554, "even if another provision of the ACA could be construed to permit" such a regulation. *California*, 2019 WL 1877392, at *21; *see also Cisneros v. Alpine Ridge Group*, 508 U.S. 10, 16 (1993) (clause "notwithstanding any other provision of

this Contract" applies "even if other provisions of the contracts might seem" to require different result).

Contrary to defendants' suggestion (Br. 34–35), Congress's decision to constitute Title X as a federal funding statute does not exempt the Final Rule from § 1554. Section 1554's broad application to "any regulation" promulgated by HHS easily encompasses regulations issued under funding statues, 42 U.S.C. § 18114. The purported distinction that defendants draw between federal funding programs and other congressional programs comes from an entirely different context: *Rust*'s discussion of the First and Fifth Amendment right to choose whether to obtain an abortion, *see* 500 U.S. at 202. The distinction thus lacks any grounding in the ACA provision at issue here or the APA. *See California*, 2019 WL 1877392, at *23. Accordingly, the district court properly determined that the Final Rule likely violates § 1554.

c. Defendants misplace their reliance on *Rust* and the presumption against implied repeal.

The repeated reliance on *Rust* by defendants (Br. 1–2, 15–21, 30–31) misses the mark because the Supreme Court's 1991 decision in *Rust* did not address either the Nondirective Mandate, which dates from 1996, or the ACA, which was enacted in 2010. As the district court correctly observed (ER16–17), the Court in *Rust* concluded that § 1008's prohibition on providing "abortion [as] a method family planning" was ambiguous under then-existing statutes

because "[a]t no time did Congress directly address the issues of abortion counseling, referral, or advocacy." 500 U.S. at 185. But "[t]he relevant statutory text" (Br. 21) has since changed. Congress in 1996 directly addressed the issues that were previously ambiguous by requiring that "all pregnancy counseling" in Title X be "nondirective," 132 Stat. at 3070–71, and prohibiting HHS from issuing regulations that impose unreasonable barriers to care or interfere with patient-provider communications, 42 U.S.C. § 18114.

Indeed, HHS has conceded that the Nondirective Mandate "imposed additional requirements" not at issue in *Rust*, 84 Fed. Reg. at 7720, and that HHS "must enforce" Congress's requirement that all Title X "pregnancy counseling be nondirective," *id.* at 7747. And defendants do not dispute that in 2010, Congress precluded HHS from issuing any regulations that violate § 1554. Far from abrogating *Rust* (Br. 2, 22), the district court properly gave effect to statutory provisions not considered in *Rust*.

Defendants' reliance on the presumption against implied repeals (Br. 22–23, 29–32) misconstrues the district court's decision. That presumption applies where two statutes might be interpreted as "in irreconcilable conflict," *Branch v. Smith*, 538 U.S. 254, 273 (2003) (quotation marks omitted), and requires courts to avoid such conflict by adopting a "reading that harmonizes the statutes," *National Ass'n of Home Builders v. Defenders of Wildlife*, 551 U.S.

644, 662 (2007). The district court correctly applied these principles here—as the motions panel acknowledged (Op. 17). As the district court explained, § 1008 continues to prohibit providers from using Title X funds for abortions. The Nondirective Mandate clarifies that, unlike funding for abortions, nondirective counseling is allowed by § 1008.[18] And the ACA limits HHS's discretion to enact certain regulations, without repealing § 1008. The statutes thus do not conflict with one another and instead work together "as a harmonious whole." *Epic Systems Corp. v. Lewis*, 138 S. Ct. 1612, 1619 (2018). It is the Final Rule—not § 1008—that conflicts with both the Nondirective Mandate and the ACA.

Defendants' arguments find no support in *Chevron, U.S.A., Inc. v. NRDC*, 467 U.S. 837 (1984). Defendants contend that any congressional enactment that clarifies ambiguity in a preexisting statute necessarily affects an implied repeal because it removes an agency's prior "authority" to interpret that statute reasonably. (*See* Br. 31–32). But this contention upends basic principles

[18] Defendants incorrectly contend (Br. 23) that interpreting the Nondirective Mandate to include referrals must impliedly repeal § 1008 because there is no "alternative interpretation of § 1008 under which a program that makes referrals" does not violate § 1008. But § 1008 is easily reconcilable with an interpretation of the Nondirective Mandate that includes referrals. (*See* ER16–17). As HHS explained both before and after *Rust*, providing referrals during pregnancy counseling does not promote abortion so long as referrals are provided in a nondirective manner. *See* 65 Fed. Reg. 41,270–75.

of statutory construction and separation of powers. *Chevron* deference comes into play when traditional tools of statutory construction leave courts with ambiguity that Congress did not resolve. *See Epic*, 138 S. Ct. at 1630. It has no application where, as here, Congress's later enactments remove statutory ambiguity and foreclose previously permissible interpretations that an agency preferred.

Contrary to defendants' contention (Br. 30, 35), there is nothing unusual about Congress using an appropriations statute to clarify the proper interpretation of an existing law. Using the appropriations process to clarify Title X makes sense because Congress wanted to preserve, rather than alter, its existing enactment and insulate that enactment from being interpreted differently going forward.

Nor is there anything surprising about Congress using § 1554 to limit HHS's authority to issue "any regulation" that imposes unreasonable barriers to healthcare or unduly interfere with patient-provider communications. 42 U.S.C. § 18114. The ACA broadly overhauled the nation's entire healthcare system and contains other provisions that, like § 1554, apply to actions taken under preexisting statutory regimes. *See id.* § 18116(a) (nondiscrimination provision extends to all federally funded health programs). Again, Congress was merely maintaining the status quo.

2. The Final Rule is arbitrary and capricious because HHS failed to adequately address the significant detriment it would cause to the Title X program and public health.

Under the APA, an agency acts arbitrarily and capriciously where it fails to engage in "reasoned decision-making" that rests on a logical "consideration of relevant factors." *Michigan v. EPA*, 135 S. Ct. 2699, 2706 (2015). Here, the district court correctly found that plaintiffs had established serious questions regarding whether the Final Rule satisfied this reasoned decision-making standard. (ER27). These serious questions amply supported the preliminary injunction given the irreparable harm to plaintiff States and the public absent the injunction. *See Alliance for the Wild Rockies*, 632 F.3d at 1131–35. In any event, plaintiffs established that the Final Rule is likely arbitrary and capricious.

First, HHS failed to provide any evidentiary support or rational explanation for its conclusion that the Rule will not "have a significant impact on access to services." 84 Fed. Reg. at 7782. *See Motor Vehicle Manufacturers Ass'n v. State Farm Mutual Auto Ins. Co.*, 463 U.S. 29, 43 (1983). Overwhelming evidence submitted to HHS demonstrates that the Final Rule will force many state and private providers to leave Title X. For example, state grantees—including Washington, New York, Hawaii, and Oregon, which together serve 427,000 Title X patients—will likely exit Title X. (Governor Cuomo Letter 2; Governor Ige Letter 1; PPFA Comment 15). And the Rule will

force Planned Parenthood to exit the program—stripping approximately 40% of all Title X patients of their trusted family-planning and healthcare providers. (ER31; PPFA Comment 15–16). Planned Parenthood's exit will be particularly devastating in States like Vermont, where Planned Parenthood is the *only* Title X provider. (Washington AG et al. Comment 24).

This mass exodus of providers will be devastating for plaintiff States, their residents, and public health. (*See* ER31–32). Providers that remain will not be able to fill the extreme gaps in Title X services. (AMA Comment 11–13; Guttmacher Comment 20; Washington AG et al. Comment 23–26; California AG et al. Comment 14). The result will be more unintended pregnancies, riskier pregnancies, more abortions, more sexually transmitted infections, and worse health outcomes. (ER31–32; NYDOH Comment 7–9; California AG Comment 14, 16).

Faced with this evidence, HHS speculated—with no support—that such harms may not occur because new providers will materialize to fill gaps in services. 84 Fed. Reg. at 7782; *see also* Tr. 60 (HHS unable to identify any new providers who might apply for Title X funding). Such "conclusory statements" do not constitute reasoned decision-making. *Getty v. Fed. Savs. & Loan Ins. Corp.*, 805 F.2d 1050, 1057 (D.C. Cir. 1986). Contrary to HHS's assertions, the current nondirective counseling requirements provide no plausible reason for

providers to refrain from joining the Title X program, because HHS does not enforce the 2000 regulations against providers or applicants with religious or moral objections to abortion. *See* 84 Fed. Reg. 23,170, 23,191 n.64 (2018). And even if a handful of providers previously stayed out of Title X for religious reasons despite the nonenforcement policy, nothing suggests that there are enough such providers to fill the void created by the exit of Planned Parenthood and other established Title X providers.

Second, the evidence that HHS possessed belies its conclusion that the Final Rule will not force medical professionals to violate medical standards of care and ethics. The Rule's counseling requirements flatly violate medical standards and ethics by requiring providers to withhold abortion-related information from patients, force patients to receive information that they have stated they do not want, and make referral decisions inconsistent with a patient's medical needs. (ER28–29; NYDOH Comment 1, 8–9; Washington AG et al. Comment 11–13; California AG et al. Comment 5–6).

There is no support for HHS's contention that the Final Rule comports with medical ethics on the ground that providers are not completely foreclosed from discussing abortion. *See* 84 Fed. Reg. at 7724. By prohibiting abortion referrals, forcing providers to hide the identities of primary care providers that offer abortion, and otherwise restricting abortion-related information, the Final

Rule prevents medical professionals from giving patients complete information. HHS's failure to grapple with such fundamental violations of medical ethics renders the Rule arbitrary and capricious. *See State Farm*, 463 U.S. at 43 (agency's decision is arbitrary and capricious if it "runs counter to the evidence before the agency").

HHS's assertions about medical ethics find no support in refusal-of-care statutes, *see* 84 Fed. Reg. at 7748, because these statutes do not address medical ethics. They restrict the government from compelling providers to conduct or refer for abortion, and prohibit certain actions against providers who refuse to give such services due to religious or moral convictions. *See* 42 U.S.C. § 300a-7; 42 U.S.C. § 238n; Weldon Amendment, Consolidated Appropriations Act, 2009, Pub. L. No. 111-117, 123 Stat 3034 (2009). Refusal-of-care laws reflect that *even if* refusing to refer for abortion violates medical ethics, a provider who does so for religious or moral reasons will be protected from certain disciplinary actions.

Third, the Final Rule's separation requirements were unnecessary to ensure that grantees do not use Title X funds for improper purposes. *See* 84 Fed. Reg. at 7763–68; 83 Fed. Reg. 25,502, 25,507 (2018). HHS identified no evidence that grantees are improperly using Title X funds or are confused by proper separation procedures. Rather, the record demonstrates that HHS and

grantees maintain robust monitoring and auditing procedures that "ensure that federal funds are used appropriately and that funds are not used for prohibited activities such as abortion."[19] (NYDOH Comment 18–19, 24–26; Washington AG et al. Comment 15–19; California AG et al. Comment 19–20). For example, HHS conducts in-depth audits of grantees and subgrantees, including onsite monitoring. (NYDOH Comment 18–19; Washington AG et al. Comment 15–17). And many States have implemented additional oversight mechanisms. (NYDOH Comment 15; Washington AG et al. Comment 17–19). Thus, unlike in *Rust*, HHS possessed decades of evidence demonstrating that Title X funds are not being used for impermissible purposes. HHS's contrary assertion in the Final Rule "runs counter to the evidence before it." *State Farm*, 463 U.S. at 43.

Fourth, HHS improperly ignored that complying with the physical-separation requirements is cost-prohibitive for many providers. (PPFA Comment 21, 30–34; Washington AG et al. Comment 23–24; NYDOH Comment 18–19). The cost estimates that HHS considered lacked any factual basis. HHS estimated—without identifying any support—that the separation requirement would cost providers $20,000 to $40,000. 84 Fed. Reg. at 7781–82.

---

[19] Angela Napili, Cong. Research Serv., R 45181, *Family Planning Program under Title X of the Public Health Service Act* at 14 (Updated October 15, 2018).

The administrative record, however, shows that many providers' expenditures will approach $625,000—more than fifteen times the highest figure HHS cited. (PPFA Comment 30–31). As a number of State Attorneys Generals explained, many providers "will effectively have to open a second clinic for every site to obtain Title X funding." (California AG et al. Comment 23). The lack of any rationale for HHS's cost figures violates the APA and further distinguishes this case from *Rust*, which was decided based on a different, now-outdated record.

HHS's lack of reasoned explanation is particularly egregious given that the Final Rule's radical departure from long-established policy will upend strong reliance interests. Title X providers have built clinics, hired personnel, and otherwise structured their operations around HHS's longstanding view that § 1008 requires only financial (but not physical) separation. (NYDOH Comment 17–19; Washington AG et al. Comment 17–19; California AG et al. Comment 10–11). And the mass exodus of providers that will result from providers exiting the program rather than restructuring their entire operations will hinder access to family-planning and medical care, and increase the cost of such care. (Washington AG et al. Comment 23–26; NYDOH Comment 18–20). HHS acted arbitrarily and capriciously in disregarding these strong reliance interests of Title X providers and the low-income patients whom Title X is

designed to serve. *See Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126 (2016) (agency regulation should account for serious reliance interests).[20]

B. The district court did not abuse its discretion in finding that plaintiffs and the public will suffer irreparable harm.

The district court's preliminary injunction merely maintains a status quo that has been in place for nearly half a century. Neither HHS nor the public at large are likely to suffer *any* irreparable harm from the preliminary injunction—let alone a harm greater than the harm that plaintiffs are likely to suffer if the Final Rule takes effect while this case is pending. Other than a single declaration in support of their motion for a stay pending appeal, defendants submitted *no* evidence to the district court on any of the factors bearing on the balance of harms or the public interest. Plaintiffs, by contrast, submitted

[20] The motion panel incorrectly suggested that HHS adequately explained its reason for adopting the counseling requirements by simply stating that it was *a* "reasonable reading of § 1008." (Op. 23). *Rust* recognized that § 1008 was ambiguous and that HHS's 1988 rule was one reasonable interpretation. But HHS has adhered to a contrary reading for most of the last fifty years. Faced with the significant damage the Rule will cause to the Title X program, HHS had to provide a reasoned explanation for why it chose *that* reading over others. *See Encino Motorcars*, 136 S. Ct. at 2125–26 (when an agency changes policy a "reasoned explanation is needed for disregarding facts and circumstances that underlay or were engendered by the prior policy"); *Judulang v. Holder*, 565 U.S. 42, 53 (2011) (courts "retain a role, and an important one, in ensuring that agencies have engaged in reasoned decisionmaking" based on relevant factors).

extensive evidence of the harms they and the public would suffer without a preliminary injunction. (ER6).

When the Final Rule takes effect, plaintiff States and the public will be irreparably harmed by the dismantling of their current Title X networks. As the district court correctly found, the harms that the Final Rule threaten to plaintiffs "are extensive and not rebutted by the government." (ER6, 32–33).

The "elimination of Title X providers [will] be detrimental to public health." (ER31–32); *see California v. Azar*, 911 F.3d 558, 581–82 (9th Cir. 2018) ("potentially dire public health" consequences from rule that would decrease contraceptive coverage). The Title X providers that remain will be unable to maintain the same quality of care due to the dramatic increase in their patient load, restrictions on counseling and referral, and the need to shift spending from patient care to administrative costs. (PSER22–23; SSER42, 83–84, 96–97). Patients will lose access to the providers they trust and rely on for care. (PSER97; SSER2–4, 28–29, 44–45, 69–71, 97).

Because the availability and quality of comprehensive preventive healthcare will decrease, the Final Rule "will result in less contraceptive services, more unintended pregnancies, less early breast cancer detection, less screening for cervical cancer, less HIV screening, and less testing for sexually transmitted disease." (ER6, 31–34; *see* PSER118–124, 172; SSER28, 47–49).

These harms will fall especially hard on patients who have low incomes, or live in rural areas or communities of color—conditions that already impose barriers to quality healthcare. (PSER3, 7, 25–28, 92; SSER52, 97). Patients in regions where affordable healthcare is scarce will thus be left with few or no options. (PSER3, 22–23; SSER52, 54, 97).

States will also suffer irreparable economic harm from the exodus of Title X providers. *See Azar*, 911 F.3d at 581–82 (9th Cir. 2018) (State's economic interest threatened by reduction in contraceptive coverage). States that are direct Title X grantees risk losing all Title X funding and every Title X clinic in their current network. *Id.* (lost Title X fund cannot be recouped from federal government); (SSER2–4, 67–68, 96–98). States that attempt to maintain their Title X programs will face significant administrative costs to do so. For example, the Oregon Health Authority estimates that it would incur almost $1 million in administrative costs to impose the structural changes required by the Final Rule. (SSER68). And States will face an increase in costs to state programs like Medicaid that will necessarily try to fill the gaps in care and address the negative health outcomes caused by the loss of Title X providers, such as more unintended pregnancies and delayed cancer diagnoses. (SSER13–16, 52, 83–84, 97–98).

Defendants brush aside all that unrebutted evidence as speculative (Br. 42–43) and the motions panel dismissed these harms as "comparatively minor" (Op. 24). But the evidence was compelling—as the district court found (ER 5–6)—and there is nothing minor about eliminating necessary healthcare for millions of low-income individuals (ER5–6, 31–32; PSER3). This case does not simply concern "ordinary compliance costs" while the appeal is pending (Br 43); it is about maintaining a stable network of providers to ensure access to reproductive healthcare. In light of the dire consequences to plaintiffs and the public, the balance of equities tips in favor of plaintiffs.

Defendants identified two supposed harms to HHS, but neither withstands scrutiny. First, HHS faces no harm in spending taxpayer dollars to enforce § 1008 as that statute has been interpreted for decades. (Br. 44–45). Defendants' contention that such spending violates § 1008 by "fund[ing] or subsidiz[ing] abortions" is predicated solely on their view of the merits. As *Rust* reflects, § 1008 itself is ambiguous on that point; HHS's new interpretation is contrary to law and arbitrary and capricious; and in any event there is *zero* evidence in the record that any Title X funds have ever been illegally diverted to funding abortions. The government "cannot suffer harm from an injunction that merely ends an unlawful practice." *Rodriguez v. Robbins*, 715 F.3d 1127, 1145 (9th Cir. 2013).

Second, the record does not support the conclusion that HHS needs a stay to avoid "significant administrative costs" or "uncertainty for the Title X program" (Br. 45)—much less that the district court abused its discretion in concluding otherwise. Defendants submitted no evidence whatsoever about any administrative costs. *See, e.g.*, *Hernandez v. Sessions*, 872 F.3d 976, 995 (9th Cir. 2017) (rejecting the government's "conclusory assertions" of harm in a declaration submitted on appeal when they were not "supported by any actual evidence"). And it is hard to imagine what those costs would be, when HHS need not do anything differently from what it has already been doing for years. As for avoiding uncertainty in the Title X program, maintaining the status quo—not disrupting it—is the surest way to protect that interest.

C. The district court did not abuse its discretion over the scope of the injunction.

The scope of the district court's preliminary injunction matches what the APA contemplates for cases like this. Under 5 U.S.C. § 705, when a reviewing court concludes that it is "necessary to prevent irreparable injury," the court is authorized "to postpone the effective date of an agency action . . . pending conclusion of the review proceedings." That is effectively what the preliminary injunction does here. The injunction preserves the status quo by prohibiting defendants from implementing the Rule while the case is pending. There is no practical difference between what the district court did here and an order

"postpon[ing] the effective date" of the Rule under 5 U.S.C. § 705. That is a complete answer to defendants' arguments about the scope of the injunction. (Br. 46–51). A nationwide injunction is appropriate because the Rule applies nationwide; postponing its effective date pending judicial review necessarily prevents its implementation anywhere. Similarly, enjoining the Rule's application to nonparties and enjoining the entire rule, not just particular sections, is appropriate because a Rule that has not come into effect cannot be applied. Because, as explained above, the Rule will cause irreparable injury if it is allowed to take effect before judicial review is complete, the district court did not abuse its discretion in adopting the interim remedy suggested by the APA itself, rather than some narrower remedy that might theoretically have been available.

But even without considering 5 U.S.C. § 705, the district court had the authority to preserve the status quo for the entire Title X program, including as to nonparty providers. *See Trump v. Int'l Refugee Assistance Project (IRAP)*, 137 S. Ct. 2080, 2087 (2017) (Supreme Court refusing to stay the portion of a preliminary injunction that covered "not just respondents, but parties similarly situated to them," because the same equities that justified relief for the parties also justified extending that relief nationwide). If plaintiffs succeed on the merits of their APA claim, they will be entitled to an order that "set[s] aside"

the agency action—here, the Rule. 5 U.S.C. § 706(2); *see Earth Island Inst. v. Ruthenbeck*, 490 F.3d 687, 699 (9th Cir. 2007), *aff'd in part, rev'd in part sub nom. Summers v. Earth Island Inst.*, 555 U.S. 488 (2009). And plaintiffs submitted unrebutted evidence that the Final Rule will have an adverse impact on public health everywhere, not just in the 21 States that sued. (*See* SSER44–49; PSER118–126, 133–138) (discussing nationwide harms). Because the ultimate relief would extend nationwide to nonparties and the equities are the same for those nonparties, it is appropriate for the preliminary injunction to cover the same scope.

The district court also did not abuse its discretion by rejecting defendants' passing request that it limit the preliminary injunction to particular provisions. (C.R. 83 p 65; Tr. 131–33). The district court correctly found problems with *both* the counseling requirements and the separation requirements, and it permissibly concluded that the rest of the Rule—the more ancillary provisions, as defendants had characterized them—could not function on their own. *See MD/DC/DE Broadcasters Ass'n v. FCC*, 236 F.3d 13, 22 (D.C. Cir. 2001) ("Whether the offending portion of a regulation is severable depends upon the intent of the agency *and* upon whether the remainder of the regulation could function sensibly without the stricken provision.") (emphasis in original); *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2319

(2016) ("[A] severability clause is an aid merely; not an inexorable command.").

CONCLUSION

The district court did not abuse its discretion in entering a preliminary injunction. This Court should affirm.

Respectfully submitted,

ELLEN F. ROSENBLUM
Attorney General
State of Oregon

/s/ Benjamin Gutman
BENJAMIN GUTMAN
Solicitor General
JONA J. Maukonen
Senior Assistant Attorney General

LETITIA JAMES
Attorney General
State of New York
BARBARA D. UNDERWOOD
Solicitor General
ANISHA S. DASGUPTA
Deputy Solicitor General

/s/ Judith N. Vale
JUDITH N. VALE
Senior Assistant Solicitor General

PHIL WEISER
Attorney General
State of Colorado

WILLIAM TONG
Attorney General
State of Connecticut

KATHY JENNINGS
Attorney General
State of Delaware

KARL A. RACINE
Attorney General
District of Columbia

CLARE E. CONNORS
Attorney General
State of Hawaii

KWAME RAOUL
Attorney General
State of Illinois

BRIAN E. FROSH
Attorney General
State of Maryland

MAURA HEALEY
Attorney General
Commonwealth of Massachusetts

DANA NESSEL
Attorney General
State of Michigan

KEITH ELLISON
Attorney General
State of Minnesota

AARON FORD
Attorney General
State of Nevada

GURBIR SINGH GREWAL
Attorney General
State of New Jersey

HECTOR BALDERAS
Attorney General
State of New Mexico

JOSH STEIN
Attorney General
State of North Carolina

JOSH SHAPIRO
Attorney General
Commonwealth of
Pennsylvania

PETER F. NERONHA
Attorney General
State of Rhode Island

T.J. DONOVAN
Attorney General
State of Vermont

MARK R. HERRING
Attorney General
Commonwealth of Virginia

JOSH KAUL
Attorney General
State of Wisconsin

CERTIFICATE OF COMPLIANCE

Pursuant to Rule 32(a)(7), Federal Rules of Appellate Procedure, I certify that the Appellee's Brief is proportionately spaced, has a typeface of 14 points or more and contains 11,513 words.

DATED: June 28, 2019

/s/ Benjamin Gutman

BENJAMIN GUTMAN
Solicitor General
benjamin.gutman@doj.state.or.us
JONA J. MAUKONEN
Senior Assistant Attorney General

Attorneys for Plaintiff-Appellee
State of Oregon

ELLEN F. ROSENBLUM
Attorney General
BENJAMIN GUTMAN
Solicitor General
JONA J. MAUKONEN
Assistant Attorney-In-Charge
1162 Court St.
Salem, Oregon 97301
Telephone: (503) 378-4402

Counsel for Appellee

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

STATE OF OREGON, et al., Plaintiffs-Appellees, v. ALEX M. AZAR, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants-Appellants.	U.S.C.A. No. 19-35386
AMERICAN MEDICAL ASSOCIATION, et al., Plaintiffs-Appellees, v. ALEX M. AZAR, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants-Appellants.	U.S.C.A. No. 19-35386 STATEMENT OF RELATED CASES

The following related cases, involving preliminary injunctions of the same Final Rule, are currently pending in this Court: *National Family Planning*

& Reproductive Health Ass'n v. Azar, No. 19-35394; *State of Washington v. Azar*, No. 19-353-94; *Essential Access Health Inc. v. Azar*, No. 19-15979.

Respectfully submitted,

ELLEN F. ROSENBLUM
Attorney General

/s/ Benjamin Gutman

BENJAMIN GUTMAN
Solicitor General
benjamin.gutman@doj.state.or.us
JONA J. MAUKONEN
Senior Assistant Attorney General

Attorneys for Plaintiff-Appellee
State of Oregon

CERTIFICATE OF SERVICE

I hereby certify that on June 28, 2019, I directed the Appellee's Brief to be electronically filed with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

/s/ Benjamin Gutman

BENJAMIN GUTMAN
Solicitor General
benjamin.gutman@doj.state.or.us

Attorney for Plaintiff-Appellee
State of Oregon

BG2:mkf/9704426