No. 19-1614

IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

MAYOR AND CITY COUNCIL OF BALTIMORE,
Plaintiff-Appellee,
v.
ALEX M. AZAR II, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,
Defendants-Appellants.

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

BRIEF FOR APPELLEE

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INTRODUCTION

This is a case of bone-chilling government overreach. Overreach justified—according to Defendants—by the holding in *Rust v. Sullivan*, 500 U.S. 173 (1991), one of the most extreme applications of the controversial *Chevron* doctrine ever rendered by the Supreme Court. Not only does *Rust* not control the outcome of this case, but the Rule the Mayor and City Council of Baltimore ("Baltimore")[1] now challenges injects the government into the doctor-patient relationship and erects unreasonable barriers to medical access and care in violation of two federal laws enacted *after Rust*. And it is currently causing Baltimore irreparable harm. The Court below correctly issued a narrowly tailored preliminary injunction preventing the Rule's implementation in the State of Maryland in anticipation of the Rule's certain vacatur.

The Rule manipulates the information medical providers give to patients in order to obstruct patients' access to abortion and to push them into following a State-sponsored policy favoring childbirth. That is the Rule's primary justification and its openly stated purpose. *See, e.g.*, 84

[1] "Baltimore" refers to the Plaintiff in this case. "Baltimore City" refers to the geographical area.

Fed. Reg. at 7758-59; Brief of Appellant ("Br.") 30,35-36. These information control and censorship tactics are associated with totalitarian regimes, not constitutional democracies. *See Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2374 (2018) (per Thomas, J.). Autocrats have long "manipulated the content of doctor-patient discourse to increase state power and suppress minorities." *Id.* (alterations omitted). "[T]he Third Reich systematically violated the separation between state ideology and medical discourse." *Id.* (quoting Paula Berg, *Toward a First Amendment Theory of Doctor–Patient Discourse and the Right To Receive Unbiased Medical Advice*, 74 B.U.L. Rev. 201, 201-202 (1994)). "Nicolae Ceausescu's strategy to increase the Romanian birth rate included prohibitions against giving advice to patients about the use of birth control devices." *Id.*

The doctor-patient relationship is one of the most intimate and important relationships in a person's life. "Doctors help patients make deeply personal decisions, and *their candor is crucial*." *Id.* (emphasis added) (citation omitted). When the Government manipulates the advice doctors give to patients, it "poses the inherent risk that the Government seeks not to advance a legitimate regulatory goal, but to suppress

unpopular ideas or information." *Id.* (alteration omitted) (citation omitted). Government manipulation of medical advice destroys patient trust in doctors and the health care system, deterring some of the most vulnerable patients from accessing the very care they desperately need. JA.216,218,221. As HHS stated in a final rule designed to protect doctors' conscience rights under the Church and Weldon Amendments under President George W. Bush:

> A *necessary* element in ensuring the best possible care for patients is protecting the integrity of the doctor-patient relationship. Patients *need* full access to their health care provider's best judgment as informed by practice, knowledge, and experience. This relationship *requires* open communication between both parties so patients can be confident that the care they seek and receive is endorsed by their health care provider.

73 Fed. Reg. 78072, 78073-74 (Dec. 19, 2008) (emphasis added).

The last time the Department of Health and Human Services (HHS) attempted such a gross intrusion into the doctor-patient relationship, in 1988, it provoked a national firestorm. *See Bush Rejects Abortion Rights Bills*, 48 CQ Almanac 387-97 (1993), http://bit.ly/2FsdxvR. Reacting to an overwhelming public outcry, President George H.W. Bush assured the nation that he interpreted the Rule to mean that "'patients and doctors [in the Title X Program] can talk

about absolutely anything they want, and they should be able to do that.'" *Nat'l Family Planning & Reprod. Health Ass'n v. Sullivan*, 979 F.2d 227, 230, 235 (D.C. Cir. 1992). But both the D.C. Circuit and Congress disagreed with that interpretation. *See id.* Substantial majorities in the House and Senate subsequently voted to rescind the Rule, falling only 12 and then 22 votes short in the House of overriding Presidential vetos. *See* Abner S. Greene, *Checks and Balances in an Era of Presidential Lawmaking*, 61 U. Chi. L. Rev. 123, 182–83 (1994).

The American people believe so strongly in the principle of government non-interference in the doctor-patient relationship that Congress has now enacted two different federal laws prohibiting HHS from manipulating the advice that medical providers give to patients. One applies specifically to the Title X program. The other applies across-the-board to every regulation HHS promulgates.

The Nondirective Mandate—first enacted in 1996 and reenacted annually by every Congress since—unambiguously bars HHS from altering the advice that medical providers in the Title X program provide to patients. *See, e.g.*, Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and

Continuing Appropriations Act, Pub. L. No. 115-245, Div. B, Tit. II, 132 Stat 2981, 3070-71 (2018). It provides that, in the Title X Program, "all pregnancy counseling shall be nondirective," *id.*, meaning, as the author of that language explained, that providers lay out legal options without directing any one course of treatment. 141 Cong. Rec. 21634 (1995) (statement of author Rep. Greenwood).

The Non-Interference Mandate—enacted as part of the Affordable Care Act ("ACA") in 2010—unambiguously bars HHS from enacting regulations that interfere with communications between doctors and their patients. *See* 42 U.S.C. § 18114. As one of the ACA's original cosponors explained, the Non-Interference Mandate "restricts the Secretary in a number of important ways from creating rules that potentially restrict access to certain benefits or settings of care." 156 Cong. Rec. 4198 (2010) (statement of Rep. Pascrell). The Mandate is "designed to permit providers to fully discuss treatment options with patients and their families and permit the patient to render an informed choice as to their course of rehabilitation or other treatment." *Id.* Not only does the Non-Interference Mandate bar HHS from interfering with doctor-patient communications, it flatly prohibits HHS from erecting

unreasonable barriers to patient access to medical care. *See* 42 U.S.C. § 18114.

HHS has thus promulgated a rule that violates unambiguous restrictions on HHS's regulatory authority set forth in two different federal statutes. This extraordinary agency overreach was the result of a rushed and fundamentally flawed rulemaking process that favored speed at all costs. The last time HHS finalized a Rule of this magnitude—the 2000 Rule—it took seven *years*. *See* 65 Fed. Reg. 41270 (July 3, 2000) (final rule); 58 Fed. Reg. 7462 (Feb. 5, 1993) (proposed rule). Here, HHS took nine *months*. *See* 84 Fed. Reg. 7714 (Mar. 4, 2019) (final rule); 83 Fed. Reg. 25502 (June 1, 2018) (proposed rule). The Rule applies to over $286 million in annual Title X spending and affects the lives of over 4 million low-income Americans along with health care services provided by every State. JA90,133-34,141,180. Title X saves the health care system over $7 billion annually by preventing diseases and unintended pregnancies, JA99,143,192-93,229, and is responsible for massively reducing the incidence of abortion in this country by promoting contraception and family planning, JA119-20,122,180. Over 40 percent of existing providers told HHS the Rule would force them out of the

program, and four States told HHS they would be forced to leave the program if the Rule went into effect. *See* HHS-OS-2018-0008-198841, http://bit.ly/2Dg5UYi. Yet, remarkably, HHS fast-tracked the Rule by concluding that the Rule is "not economically significant," and "does not . . . have federalism implications." 84 Fed. Reg. at 7776-77.

Numerous commenters—blindsided by HHS's sudden announcement of a proposed Rule of such significance—asked HHS to extend the comment period beyond a mere 60 days, arguing it was unreasonably short (the APA sets no fixed length for a comment period). *See* HHS-OS-2018-0008-204437, http://bit.ly/2JJiF1h; HHS-OS-2018-0008-204370, http://bit.ly/32B1UNb. HHS refused. Even so, the Proposed Rule provoked over 500,000 comments including opposition from some of the nation's leading non-partisan medical associations, including the American Medical Association (AMA), 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. Those organizations argued that the Rule requires doctors to violate fundamental tenets of medical ethics, destroys the integrity of the doctor-

patient relationship, and will eviscerate patient trust. HHS's answer to these points in the Rule appears in two short paragraphs—backed by no evidence or argument—stating only that HHS "disagrees" with these medical organizations about the requirements of medical ethics. 84 Fed. Reg. at 7724, 7748.

The agency's reasoning is indefensible. So Defendants do not try to defend it. Defendants instead pin their case on a new argument, introduced at the litigation stage, that the Supreme Court's decision in *Rust*—upholding the 1988 Rule as a permissible reading of § 1008's (codified as 42 U.S.C. § 300a-6) ("§ 1008") "ambiguous" language, 500 U.S. at 184—means that the Nondirective and Non-Interference Mandates cannot apply to the Rule at all, notwithstanding their unambiguous text. According to Defendants, unless a statute enacted after *Rust* expressly mentions *Rust*, it cannot affect HHS's subsequent authority to enact a rule similar to the rule *Rust* upheld. Br.2,31,38.

Defendants' belief in a "*Rust* clear statement" rule is wrong for least five different reasons. First, it contradicts basic principles of statutory interpretation: that later-enacted and more specific statutes "frequently" modify the meaning of ambiguous earlier statutes. *United States v.*

Fausto, 484 U.S. 439, 453 (1988) (per Scalia, J.). Second, it contradicts HHS's own acknowledgement during this rulemaking that the Nondirective Mandate *does* constrain its regulatory authority under Title X, *see, e.g.*, 84 Fed. Reg. at 7745, 7777, and it contradicts other HHS rulemakings where HHS has acknowledged that the Non-Interference Mandate applies to its regulatory authority as well. *See, e.g.*, 84 Fed. Reg. at 23223-24; 83 Fed. Reg. at 57551-52; 83 Fed. Reg. at 57608. Third, it misapplies the presumption against implied repeals, which is only triggered when two statutes irreconcilably conflict. *Nat'l Ass'n of Home Builders v. Defs. of Wildlife,* 551 U.S. 644, 662 (2007). Fourth, *Rust* did not address the Nondirective and Non-Interference Mandates—meaning that *even if they had existed at the time of Rust*, *Rust* still would not apply to them. Fifth, even if this were a case where the Nondirective and Non-Interference Mandates conflicted with *Rust* (and they do not), the unambiguous text of those later-enacted statutes would still control.

Defendants' reliance on *Rust* is all the more remarkable because *Rust* did not issue a holding regarding the necessary or even the likely meaning of any provision of Title X. 500 U.S. at 184-187. *Rust* is the quintessential *Chevron* Step Two case—a case where the Supreme Court

called a statute "ambiguous" and then deferred to the agency's interpretation. *See id.* at 184.

In fact, *Rust* is one of the most extreme applications of the *Chevron* doctrine in the Supreme Court's history. *See, e.g.*, Bernard Schwartz, *"Apotheosis of Mediocrity"? The Rehnquist Court and Administrative Law*, 46 Admin. L. Rev. 141, 176 (1994); Greene, *Checks and Balances*, *supra* at 182-83. *Rust* has been called "extremely deferential," "a willing abandonment of the task of statutory interpretation to an agency," and a relinquishment by the Court to the President of "extraordinary lawmaking power." Phillip J. Cooper, *Rusty Pipes: The Rust Decision and the Supreme Court's Free Flow Theory of the First Amendment*, 6 Notre Dame J.L. Ethics & Pub. Pol'y 359, 377–78 (1992) ("a willing abandonment"); Greene, *Checks and Balances*, *supra* at 184 ("extraordinary lawmaking power"); *see also* Steven G. Gey, *Reopening the Public Forum—from Sidewalks to Cyberspace*, 58 Ohio St. L.J. 1535, 1599 (1998) (calling *Rust* "extremely deferential").

There is substantial question whether *Rust* was correctly decided even in 1992, before the existence of the two statutes that doom this rulemaking. *Rust*-style *Chevron* deference "precludes judges from

exercising [independent] judgment" and "wrests from Courts the ultimate interpretative authority to say what the law is." *Michigan v. EPA*, 135 S. Ct. 2699, 2712 (2015) (Thomas, J., concurring); *see Pereira v. Sessions*, 138 S. Ct. 2105, 2120-21 (2018) (Kennedy, J., concurring); *City of Arlington, Tex. v. FCC*, 569 U.S. 290, 315 (2013) (Roberts, C.J., dissenting); *Gutierrez-Brizuela v. Lynch*, 834 F.3d 1142, 1149 (10th Cir. 2016) (Gorsuch, J., concurring). The Department of Justice has opposed *Chevron* deference in other cases. Recently the Department "went so far as to indicate that . . . if the Rule's validity turns on the applicability of *Chevron*, it would prefer that the Rule be set aside rather than upheld under *Chevron*." *Guedes v. ATF*, 920 F.3d 1, 21 (D.C. Cir. 2019). The Supreme Court in *Rust* abdicated the fundamentally judicial task of saying what the law is; *Rust* is far from persuasive precedent regarding Title X's meaning; and *Rust* says nothing about the meaning of Title X at all, only what the Court concluded it *could* "plausibl[y]" have meant in 1992. Indeed, there is substantial question whether, without *Chevron*, the Rule represents a reasonable reading of § 1008. But Congress's subsequent enactment of the Nondirective and Non-Interference Mandates makes it unnecessary to revisit the question.

The Rule violates the Nondirective and Non-Interference mandates. And it will cause Baltimore irreparable harm, as the Court below correctly and persuasively held. As the district court found, Baltimore will be forced to withdraw from Title X should the Rule ultimately take effect. JA270. And other providers throughout Maryland and neighboring States will also withdraw, further amplifying Baltimore's harms. JA271. Providers that remain in the Program will be forced to provide medical care that destroys patient trust and will deter those patients from utilizing needed preventative care and other medical services while their health further deteriorates, intensifying Baltimore's harms. JA217. Against those extraordinary and irreparable harms, the Government contends—consistent with its speed-at-any-cost approach to the Rule—that it will be irreparably harmed by delay alone. JA272. That "harm" is inconsequential, not irreparable, and pales in comparison to Baltimore's harms as the Court below correctly held. *Id.*

Defendants' appeal is meritless. This case demanded a preliminary injunction and the District Court correctly issued one narrowly tailored to preventing implementation of the Rule in Maryland pending the Rule's vacatur. Defendants' arguments about severability are meritless and

waived, and the injunction is not even close to overbroad in light of the serious harms that would befall Baltimore from a narrower injunction. This Court should affirm.

BACKGROUND

I. STATUTORY AND REGULATORY BACKGROUND

A. The Creation of the Title X Family Planning Program

Title X originated as a response to a growing body of evidence in the 1960s that demonstrated adverse health and economic outcomes caused by low-income individuals' unequal access to modern, effective contraception. Low-income women had twice the rates of unintended pregnancies compared to more affluent women, and their more closely-spaced pregnancies led to poor health outcomes for themselves and their children. Unintended, mistimed, and unwanted childbearing worsened poverty levels and educational attainment, limiting women's control over their lives. At the same time, evidence showed that newly available and highly effective contraceptive options, such as "the Pill," were unaffordable for too many. In light of these findings, there was bipartisan agreement that the federal government should support voluntary family planning programs as a means of equalizing access to

modern, effective contraceptive methods and improving public health outcomes. JA83-86,130.

In 1969, President Richard Nixon delivered a special message to Congress. President Nixon decried the role of "involuntary childbearing" in the perpetuation of poverty. Richard Nixon, *Special Message to the Congress on Problems of Population Growth* (July 18, 1969), http://bit.ly/2SgXje3. "[N]o American woman should be denied access to family planning assistance because of her economic condition." *Id.*

Congress responded to President Nixon's call in 1970 by enacting Title X of the Public Health Services Act, a bipartisan effort to provide federal funding for family planning services, with the primary purpose of "assist[ing] in making comprehensive voluntary family planning services readily available to all persons desiring such services." Pub. L. No. 91–572, § 2, 84 Stat. 1506 (1970) (codified as amended at 42 U.S.C. §§ 300 – 300a-8) ("Title X"); s*ee, e.g.,* Richard Nixon, Statement on Signing the Family Planning Services and Population Research Act of 1970, The American Presidency Project, https://bit.ly/2GqM1iM (discussing "strong bipartisan support"). Then-Congressman George H.W. Bush sponsored the Bill.

B. The Impact of the Title X Program

Almost fifty years after its passage, Title X is a public health triumph, having helped create a strong network of providers committed to supporting the delivery of quality preventive health services, including reproductive care. Title X is the only federal program dedicated solely to supporting the delivery of family planning and related preventive health care. It is designed to provide contraceptive supplies and information to all who want and need them, with priority given to persons from low-income families. In addition to offering a broad range of effective and acceptable contraceptive methods on a voluntary and confidential basis, Title X-funded service sites provide contraceptive education and counseling; breast and cervical cancer screening; testing, referral, and prevention education for sexually transmitted infection (STI) and human immunodeficiency virus (HIV); and pregnancy diagnosis and counseling. JA26,130. The program has been a resounding success in preventing an estimated 822,000 unintended pregnancies, 87,000 low-weight births, 63,000 STIs, and 2,000 cervical cancers every year. JA135-41.

C. The Original Regulations Governing the Title X Program

Title X gives the Secretary authority to promulgate grant-making regulations, 42 U.S.C. § 300a-4(a). In 1971, the Department issued its first regulations implementing Title X. It required each grantee of Title X funds to provide assurances that, among other things, priority will be given to low-income individuals, services will be provided "solely on a voluntary basis" and "in such a manner as to protect the dignity of the individual," and the "project will not provide abortions as a method of family planning." 36 Fed. Reg. 18,465, 18,466 (Sept. 15, 1971), *codified at* 42 C.F.R. § 59.5(9) (1972). Each program was to provide "medical services related to family planning including physician's consultation, examination, prescription, continuing supervision, laboratory examination, contraceptive supplies, and necessary referral to other medical facilities when medically indicated" and include "[p]rovision for the effective usage of contraceptive devices and practices." *Id.*

The regulatory requirement that abortion not be a method of family planning stems from a provision of the statute. Section 1008 of Title X provides that no Title X funds "shall be used in programs where abortion is a method of family planning." 42 U.S.C. § 300a-6. That provision

means exactly what it says. It was never intended to interfere with communications concerning abortion between a Title X provider and a patient—as Congress and HHS have repeatedly made clear.

Representative John Dingell, the sponsor of the amendment adding § 1008, opposed "restrictions on [abortion] counseling and referral." 53 Fed. Reg. 2922, 2930 (Feb. 2, 1988). The amendment was added, instead, in recognition of the fact that in 1971 the criminal laws of many states prohibited abortion, and that federal funds should not be used to perform procedures that would violate state criminal law. As Representative Gerry Studds later stated: "When we created the Title X program 20 years ago, we did not intend to muzzle health care providers . . . . [L]et there be no mistake. Title X providers must be able to inform individuals of all pregnancy management options." 138 Cong. Rec. 9,872 (1992) (statement of Rep. Studds).

Through the first 18 years of Title X's existence, HHS never took a contrary view. In 1980, for example, HHS promulgated new regulations that retained many of the same provisions as those in the 1971 regulations, including those discussed above. 45 Fed. Reg. 37,433, 37,437 (June 3, 1980), *codified at* 42 C.F.R. § 59.5(5) (1980). The following year,

the Department issued "Program Guidelines" "to assist current and prospective grantees in understanding and utilizing the Title X family planning services grants program." JA34. These guidelines specified that Title X projects were to provide nondirective pregnancy counseling, including on the option of abortion to patients who wanted such counseling. *Id.*

D. The 1988 Attempt to Fundamentally Alter the Title X Program and the Response To It

In 1988, the Reagan Administration promulgated extensive new regulations related primarily to § 1008. The 1988 regulations provided, for the first time in the program's history, that Title X covers "preconceptional" services only. 53 Fed. Reg. 2922 (Feb. 2, 1988), *codified at* 42 C.F.R. § 59.2 (1988) ("1988 rule").

The 1988 Rule established a broad prohibition on abortion counseling and referral, including a "gag rule," applicable to all Title X project personnel, that prohibited them from providing "counseling concerning the use of abortion as a method of family planning" and "referral for abortion as a method of family planning." *Id.* § 59.8. The 1988 regulations also imposed a new requirement that a "Title X project must be organized so that it is physically and financially separate" from

abortion-related services. *Id.* § 59.9. Whether adequate separation existed was based on a set of factors that included the degree of separation between treatment, consultation, examination, and waiting rooms, and separate personnel. *See id.*

The 1988 Gag Rule faced vast opposition and was also the subject of extensive litigation. It was swiftly enjoined and was never fully implemented due to ongoing litigation and bipartisan concern over its invasion of the medical provider-patient relationship. Ultimately, the Supreme Court upheld the 1988 regulations against a facial challenge in *Rust v. Sullivan*, 500 U.S. 173 (1991). *Rust* held that § 1008 was "ambiguous," making the the 1988 Rule's interpretation of Title X "permissible" at that time. *See Rust,* 500 U.S. at 184-87.

On November 5, 1991, just over five months after the decision in *Rust* and in response to widespread concerns (expressed both before and after *Rust*) that the 1988 Gag Rule unduly interfered in the medical provider-patient relationship, President George H.W. Bush issued a memorandum to the Secretary of HHS attempting to undo the Gag Rule. George H.W. Bush, Message to the Senate Returning Without Approval the Family Planning Amendments Act of 1992 (Sept. 25, 1992). In a press

conference, the President stated: "[U]nder my directive, they can go ahead—patients and doctors can talk about absolutely anything they want, and they should be able to do that." *See Nat'l Family Planning & Reprod. Health Ass'n, Inc. v. Sullivan*, 979 F.2d 227, 230 (D.C. Cir. 1992). The D.C. Circuit held that President Bush's directive effectively repealed the Gag Rule and thus required notice and comment rulemaking to implement. *See id.* at 241. The Court enjoined HHS from implementing President Bush's directives. *See id.*

For its part, Congress reacted to the 1988 regulations by waging all-out war to repeal them until they were officially revoked by HHS in 1993, often coming within a handful of votes of overriding Presidential vetos. Numerous bills were introduced, as were numerous appropriations riders. *See Bush Rejects Abortion Rights Bills*, 48 CQ Almanac 387-97 (1993), http://bit.ly/2FsdxvR.

On January 22, 1993, President Clinton issued a memorandum to the Secretary of HHS directing her to suspend the 1988 rule's prohibition on abortion counseling and referral because, among other reasons, it "endanger[ed] women's lives and health by preventing them from receiving complete and accurate medical information and interfere[d]

with the doctor-patient relationship by prohibiting information that medical professionals are otherwise ethically and legally required to provide to their patients." *Memorandum for the Secretary of Health and Human Services*, 58 Fed. Reg. 7,455 (Jan. 22, 1993). HHS issued an interim final rule, revoking the 1988 Rule and proposing to reinstate the earlier Title X regulations. 58 Fed. Reg. 7462 (Feb. 5, 1993) (proposed rule).

E. Changes to Title X After The Failed 1988 Attempt to Rewrite Title X

1. Changes to the Statutory Landscape—The Nondirective Mandate and the Non-Interference Mandate

Starting in 1996 Congress began enacting the Nondirective Mandate—requiring as part of its annual Title X appropriations that "all pregnancy counseling shall be nondirective." *See, e.g.*, Continuing Appropriations Act, 2019, P.L. 115-245, Div. B, Title II, §§ 207 and 208 (2018); Consolidated Appropriations Act, 2018, P.L. 115-141, Div. H, Title II, 132 Stat. 348, 716-17 (2018); Consolidated Appropriations Act, 2017, P.L. 115-31, Div. H, Title II, 131 Stat. 521 (2017).

This is no ancillary provision. The Nondirective Mandate appears under the heading "FAMILY PLANNING" in the Appropriations Act and the relevant paragraph states in its entirety:

> For carrying out the program under title X of the PHS Act to provide for voluntary family planning projects, $286,479,000: *Provided*, That amounts provided to said projects under such title shall not be expended for abortions, **that all pregnancy counseling shall be nondirective**, and that such amounts shall not be expended for any activity (including the publication or distribution of literature) that in any way tends to promote public support or opposition to any legislative proposal or candidate for public office.

Pub. Law. No. 115-245, Title II, 132 Stat. 2981, 3070-71 (Sept. 28, 2018) (emphasis added).

The legislative history of the enactment of the initial provision in 1996 is sparse and equivocal. Given that Congress reenacts the provision every year, the relevance of its initial legislative history is hard to grasp. *See* Br.32 (arguing that 1996 legislative history showed Congressional intent to prevent Title X funds from being used to provide abortions or from advocating that a client choose abortion). But even if it is relevant, the initial legislative history is consistent with the view that Congress enacted the Nondirective Mandate specifically to cement the standard in the existing regulations and prevent providers from steering patients

toward or away from abortion. As a supporter of the Mandate explained, "[n]o one has ever been counseled to have an abortion by a title X clinic. It is against the law to do that." 141 Cong. Rec. 21638 (1995) (statement of Rep. Porter). And as an opponent of the Mandate explained (as reason to oppose it), "[t]he Greenwood amendment . . . merely restates current law and policy with respect to Title X recipients and abortion funding, counseling, and lobbying with Federal funds." *Id.* at 21637 (statement of Rep. Smith.).

In 2010, as part of the Affordable Care Act (ACA), Congress included a provision emphasizing the importance of nondirective counseling and uninhibited patient access to all information that health care professionals determine is ethically and medically necessary for informed consent. Section 1554 ("Access to Therapies") of the ACA, reaffirmed the core principles underlying the existing regulations and statutory requirement for nondirective counseling, and provides that the Secretary of HHS "shall not promulgate any regulation" that:

> (l) 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; [or]
>
> (5) violates the principles of informed consent and the ethical standards of health care professionals.

42 U.S.C. § 18114 ("Non-Interference Mandate"). The legislative history shows that Congress intended § 1554 to apply boadly to every regulation the HHS Secretary promulgates. *See* 156 Cong. Rec. 4197-98 (2010) (statement of Rep. Pascrell).

2. Changes to the Regulatory Landscape—The 2000 Regulations

The 1993 regulations were finalized in 2000, memorializing the same regulatory approaches that had governed since Title X's inception, and have been in place ever since. 65 Fed. Reg. 41,270 (July 3, 2000), *codified at* 42 C.F.R. Part 59. Moreover, consistent with longstanding interpretations of § 1008, as well as Congress's repeated directives in annual appropriations acts, the 2000 Rule requires—upon a patient's request—nondirective counseling for all pregnancy options. 42 C.F.R. § 59.5(a)(5). As the 2000 Rule makes clear, the policies and interpretations set forth therein "have been used by the program for virtually its entire history; indeed, they have been in effect during the pendency of this rulemaking." 65 Fed. Reg. at 41,271.

With respect to nondirective counseling and referrals, HHS found that the restriction on counseling and referrals set forth in the 1988 regulations "endangers women's lives and health by preventing them from receiving complete and accurate medical information and interferes with the doctor-patient relationship by prohibiting information that medical professionals are otherwise ethically and legally required to provide to their patients." *Id.* at 41,270. HHS also determined that "requiring a referral for prenatal care and delivery or adoption where the client rejected those options would seem coercive and inconsistent with" Congress's nondirective counseling requirement. *Id.* at 41,275.

With respect to the 1988 "Separation Requirement," the agency provided the following explanation for eliminating it:

> If a Title X grantee can demonstrate by its financial records, counseling and service protocols, administrative procedures, and other means that—within the identified set of Title X-supported activities—promotion or encouragement of abortion as a method of family planning does not occur, then it is hard to see what additional statutory protection is afforded by the imposition of a requirement for "physical" separation. Indeed, in the light of the enforcement history noted above, it is not unreasonable to say that the standard of "physical" separation has, as a practical matter, had little relevance or applicability in the Title X program to date. Moreover, the practical difficulty of drawing lines in this area, both as experienced prior to 1988 and as evident in the history of the Gag Rule itself, suggests that this legal interpretation

> is not likely ever to result in an enforceable compliance policy that is consistent with the efficient and cost-effective delivery of family planning services.

Id. at 41,276. Thus, according to HHS's 2000 regulations, Title X grantees may share facilities that host Title X programs and provide abortion care "so long as it is possible to distinguish between the Title X supported activities and non-Title X abortion-related activities." *Id.* at 41,282. Common waiting rooms, common staff, and maintenance of a single filing system are all permissible as long as costs are properly prorated or allocated between Title X projects and other programs.

HHS's Office of Population Affairs (OPA) provides strict oversight of projects that receive Title X grants to ensure that federal funds are used in a manner consistent with the regulations and funds are not used for any ineligible activities, such as abortion services. Existing safeguards to maintain this separation include: (1) careful review of grant applications to ensure that the applicant understands and has the capacity to comply with all requirements; (2) independent financial audits to examine whether there is a system to account for program-funded activities and non-allowable program activities; (3) yearly comprehensive reviews of the grantees' financial status and budget

report; and (4) periodic and comprehensive program reviews and site visits by OPA regional offices. JA 38-39.

In addition to the 2000 regulations, Title X grantees are also required to follow HHS's "QFP"—a 2014 publication entitled "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs" that is incorporated into the Program Requirements. The QFP, prepared by the Centers for Disease Control and Prevention (CDC) and OPA, both of which are housed within HHS, is a careful, extensive, evidence-based description of the best practices for providing family planning services in the United States. Its recommendations were "developed jointly under the auspices of CDC's Division of Reproductive Health (DRH) and the Office of Population Affairs (OPA), in consultation with a wide range of experts and key stakeholders," which included a "multistage process that drew on established procedures for using clinical guidelines" developed by "family planning clinical providers, program administrators, representatives from relevant federal agencies, and representatives from professional medical organizations." CDC, *Providing Quality Family Planning Services Recommendations of CDC and the U.S. Office of Population*

Affairs, 63(4) Morbidity and Mortality Weekly Report, at 3 (Apr. 25, 2014), http://bit.ly/2M2P4kW.

This process included "[s]ystematic reviews of the published literature from January 1985 through December 2010," *id.* at 30, and the report itself (excluding its appendices) contains over 150 citations to scholarly publications. The American College of Obstetricians and Gynecologists, the American College of Physicians, and the American Academy of Family Physicians all endorse nondirective options counseling, including referral to appropriate providers, as the most clinically appropriate role for providers caring for a patient who is facing an unexpected pregnancy.

The QFP reflects this consensus. It requires that for pregnant patients, "[o]ptions counseling should be provided in accordance with recommendations from professional medical associations, such as ACOG [the American College of Obstetricians and Gynecologists] and AAP [the American Academy of Pediatrics]." *Id.* at 14. ACOG and AAP's *Guidelines for Perinatal Care* state that providers should "[a]ssess all patients' desire for pregnancy. If the patient indicates that the pregnancy is unwanted, she should be fully informed in a balanced

manner about all options, including raising the child herself, placing the child for adoption, and abortion." AAP & ACOG, Guidelines for Perinatal Care 127 (7th ed. 2017), http://bit.ly/2K5aawe.

These standards allow patients to trust their Title X providers and ensure the delivery of unbiased information regarding their reproductive and sexual health. JA148-49. This high standard of care respects the dignity and autonomy of patients and helps them make the best decisions for themselves and their loved ones when facing an unintended pregnancy or other time-sensitive decisions about their reproductive health. *E.g.*, JA199-200,202.

On December 22, 2017, the CDC published an update to the QFP, which stated that after a thorough review, "CDC and the Office of Population Affairs determined that none of the newly published recommendations [since 2014] marked a substantial shift in how family planning care should be provided." Loretta Gavin et al., *Update: Providing Quality Family Planning Services – Recommendations from CDC and the Office of Population Affairs, 2017*, 66(50) Morbidity & Mortality Weekly Report 1383 (Dec. 22, 2017), http://bit.ly/2SBNpDW.

That is, as of December 2017, the Defendants concluded that no new evidence supported any significant changes to the QFP.

F. HHS's Proposed Rule

On June 1, 2018, HHS issued a proposed rule that would overhaul the longstanding Title X regulations in numerous respects. 83 Fed. Reg. 25,502 (Jun. 1, 2018) (the "Proposed Rule").

The Proposed Rule was moved through the Office of Information and Regulatory Affairs (OIRA) at the Office of Management and Budget (OMB)—a process that even for an insignificant rule typically takes months—in less than two weeks. *See* HHS-OS-2018-0008-204437, http://bit.ly/2JJiF1h (letter from Sens. Hassan and Harris cataloguing procedural irregularities). The Proposed Rule never appeared on the public Fall 2017 or Spring 2018 Regulatory Agendas, *see id.*, even though Agencies are supposed to place anticipated regulatory actions on the Agenda twelve months in advance. *See* OMB, *About the Unified Agenda*, http://bit.ly/2JPVcLT. There was no early outreach to affected stakeholders, as is policy under Executive Order 13563, § 2.c. and associated OMB/OIRA guidance. *See* HHS-OS-2018-0008-204437, http://bit.ly/2JJiF1h. Despite that lack of public engagement, OMB

denied stakeholder groups' requests for meetings during the two weeks the Proposed Rule was under Regulatory Review prior to its proposal in the Federal Register. *See id.*

HHS received over 500,000 public comments opposing the Proposed Rule—including extensive comments from major medical associations, major Title X providers and policy and research organizations, nearly 200 members of Congress, and several states.

California, along with Connecticut, Delaware, Hawaii, Illinois, Iowa, Maine, Maryland, Minnesota, New Jersey, New Mexico, North Carolina, and the District of Columbia filed a multistate comment letter explaining that the Rule, if implemented, would create barriers to women's health care, including abortion. HHS-OS-2018-0008-161828, https://bit.ly/2K2eE70.

The leading American health organizations also submitted comment letters strongly condemning the proposal. These groups included the AMA, HHS-OS-2018-0008-179739, http://bit.ly/2Zexyyi, the American College of Obstetricians and Gynecologists, HHS-OS-2018-0008-179339, http://bit.ly/2ZjlEDt, the American College of Physicians, HHS-OS-2018-0008-184400, https://bit.ly/2Yd6jCs, the American

Academy of Family Physicians, HHS-OS-2018-0008-102966, https://bit.ly/2SEl2VQ, the American Academy of Nursing, HHS-OS-2018-0008-106624, https://bit.ly/2Yd6opK, the American Academy of Pediatrics, HHS-OS-2018-0008-181588, https://bit.ly/32OLd0I, and Planned Parenthood Federation of America, HHS-OS-2018-0008-198841, http://bit.ly/2Dg5UYi.

Policy and research organizations such as the Guttmacher Institute, the American Civil Liberties Union, and the National Family Planning & Reproductive Health Association described the significant negative impacts that the Proposed Rule would likely have on patients, particularly members of vulnerable populations, including women of color, LGBTQ people, and victims of intimate partner violence. Guttmacher, HHS-OS-2018-0008-177880, http://bit.ly/2PdgLXO; ACLU, HHS-OS-2018-0008-190184, http://bit.ly/2IpI7cO; NFPRHA, HHS-OS-2018-0008-192227, http://bit.ly/2VVVOmw. These comments—like many others—cited to myriad empirical studies, case studies, and other research indicating the dramatically unfavorable outcomes likely to result from the Proposed Rule. In addition, a number of organizations representing public health professionals and community health centers,

along with thousands of individual Americans from across the country, submitted comments expressing grave concerns about the Proposed Rule as drafted.

In a nearly 100-page comment letter, Planned Parenthood urged HHS to withdraw the Proposed Rule in its entirety, challenging virtually all of its provisions and arguing that the proposal was legally flawed and would harm patient care. HHS-OS-2018-0008-198841, http://bit.ly/2Dg5UYi. Planned Parenthood warned that the Gag Rule alone would result in a mass exodus of providers from the Title X program—including all Planned Parenthood affiliates and numerous states—leading to reduced patient care on a vast scale. *Id.* at 15-17. Planned Parenthood also explained that the Separation Requirements were extremely onerous and vague, and effectively disqualified it from the Title X program because of its speech and conduct outside of the Title X program. *Id.* at 34-35, 39-40.

The AMA also voiced its strong opposition to the Proposed Rule. HHS-OS-2018-0008-179739, http://bit.ly/2Zexyyi. Its letter urged HHS to abandon its attack on family planning services, explaining that it would undermine patients' access to high-quality medical care and

information, dangerously interfere with the patient-physician relationship, conflict with physicians' ethical obligations, exclude qualified providers, and jeopardize public health. *See id.*

The AMA made clear that "frank and confidential communications with . . . patients ha[ve] always been a fundamental tenet of high quality medical care." *Id.* at 1. "A physician must always have the ability to freely communicate with his or her patient, providing information to patients about their health and safety, without fear of intrusion by government and/or other third parties. Regulations that restrict the ability of physicians to explain all options to their patients and refer them, whatever their health care needs, compromise this relationship and force physicians and other health care providers to withhold information that their patients need to make decisions about their care." *Id.* at 2.

G. HHS's Final Rule

On March 4, 2019, HHS published the Final Rule, 84 Fed. Reg. 7714 (Mar. 4, 2019). Despite the outpouring of opposition through public comments, the Rule retains key provisions of the Proposed Rule, significantly altering HHS's previous interpretation of Title X. It also

includes new provisions, such as the speaker-based ban on pregnancy counseling, 42 C.F.R. §§ 59.2, 59.14, on which the public did not have an opportunity to offer comment. The Rule introduces numerous changes to the Title X regulations that have been in place for decades, and contains several overlapping provisions regarding abortion counseling that require physicians to withhold counseling related to pregnancy termination and direct patients to prenatal care. § 59.14.

1. Directive Counseling Requirements

Limitation on Referrals: The Rule forbids all medical providers at a Title X funded facility from making referrals for abortion services. *See* §§ 59.5(a)(5), 59.14(a). Even if a patient specifically requests a referral to an abortion provider, a Title X project can, at most, provide a list on which most of the providers must *not* provide abortions, § 59.14(c)(2), and "[n]either the list nor project staff may identify which providers on the list perform abortion." *Id.* The list cannot include specialty clinics that do not also provide comprehensive primary health care, even though these clinics are the most cost-effective and convenient providers in places like Baltimore, and often the most appropriate. JA97-98,220-21. Nor can providers inform the patient that the list omits these

providers. § 59.14(c)(2). Further, this so-called "referral" list" "may be limited to those that do not provide abortion at all." *Id.*

Mandatory Referral to Prenatal Care: When a Title X patient is confirmed to be pregnant, the Rule requires that the patient "shall be referred to a health care provider for medically necessary prenatal health care," § 59.14(b)(1), even if the patient has decided not to carry the pregnancy to term, and even if she has expressly stated that she does not want such a referral.

Other Limitations on Counseling: The Rule eliminates the requirement that Title X providers provide "[n]ondirective pregnancy counseling." § 59.14(b)(1) ("Title X provider may" but is not required to, provide "[n]ondirective pregnancy counseling."). Morever, "[n]ondirective pregnancy counseling" can only be "provided by physicians or advanced practice providers [("APPs")]," *id.*, defined as "a medical professional who receives at least a graduate level degree in the relevant medical field and maintains a license to diagnose, treat, and counsel patients," § 59.2. As a result, professionals like registered nurses and social workers cannot provide such counseling. And again,

"nondirective pregnancy counseling" may not include a referral for pregnancy termination. *See* 59.14(c)(2).

These counseling and referral restrictions represent a sharp break from the 2000 regulations, as well as the prior 1981 guidelines. Until now, Title X grantees have been required to offer pregnant women nondirective pregnancy counseling and referral upon request. 42 C.F.R. § 59.5(a)(5). Grantees have not been required to refer a woman who did not intend to continue her pregnancy to prenatal care, and no restrictions were placed on referral lists.

2. The Separation Requirement

The Rule contains an onerous "physical and financial" separation requirement that few providers can realistically meet. Under the Rule, "[a] Title X project must be organized so that it is physically and financially separate . . . from activities which are prohibited under section 1008 of the Act and §§ 59.13, 59.14, and 59.16 of these regulations from inclusion in the Title X program." § 59.15. "In order to be physically and financially separate, a Title X project must have an objective integrity and independence from prohibited activities," and "[m]ere bookkeeping separation of Title X funds from other monies is not

sufficient." *Id.* The Secretary will determine whether such objective integrity and independence exist by looking to relevant factors that include: "The existence of separate, accurate accounting records"; "[t]he degree of separation [of] facilities (*e.g.*, treatment, consultation, examination and waiting rooms, office entrances and exits, shared phone numbers, email addresses, educational services, and websites)"; "[t]he existence of separate personnel, electronic or paper-based health care records, and workstations"; and 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 rule does not only require such separation of Title X projects from abortion services, but also from medical care that could involve referral for abortion. *Id.* at § 59.13.

The new Separation Requirement again represents a marked departure from the current rule. Under the 2000 regulations, grantees' abortion activities were required to be financially separate from their Title X activities, but "[c]ertain kinds of shared facilities [we]re permissible, so long as it [wa]s possible to distinguish between the Title X supported activities and non-Title X abortion-related activities." 65

Fed. Reg. at 41281. For example, common waiting rooms and staff were permissible, as long as the costs and salaries were properly pro-rated and allocated. *Id.*

3. The Family Participation Requirement

Finally, the Rule contains another harmful provision that requires Title X grantees to "[e]ncourage family participation in the decision to seek family planning services; and, with respect to each minor patient, ensure that the records maintained document the specific actions taken to encourage such family participation (or the specific reason why such family participation was not encouraged)." § 59.5(a)(14). This requirement will jeopardize adolescent trust in their providers and discourage them from seeking needed care. JA218-19. The 2000 regulations contained no such requirement.

H. Baltimore's Participation in the Title X Program

Baltimore has participated in the Title X program since its inception. JA225. The Baltimore City Health Department currently receives $1,430,000 annually in funding subject to Title X rules through subgrants from the Maryland Department of Health. JA229. It directly operates three community clinics and four school-based health centers that provide Title X services, and provides funding to ten additional

subgrantees in the city. Planned Parenthood operates additional Title X sites within Baltimore City. JA225-26. The Title X program serves as the final safety net for healthcare for one third of women living in Baltimore City. JA226. In 2017, 16,000 patients in Baltimore City received care through Title X clinics, including 7,670 patients at clinics with funding overseen by Baltimore City Health Department. 99.8% of these patients had incomes at or below 250% of the federal poverty line, and 86% had incomes at or below the line. JA226. The 2019 federal poverty line for a family of three was $21,330. HHS Poverty Guidelines for 2019, http://bit.ly/2GtcGeZ.

The services provided by Baltimore's existing network of qualified Title X providers have a significant, positive impact on family health and well-being, and by extension on public health generally. Government investment in contraception promotes public health and is cost effective. For example, in 2010, every dollar invested in publicly funded family planning programs like Title X, federal and state governments saved an estimated $7.09 in Medicaid-related costs that would otherwise have been associated with unintended pregnancies as well higher rates of adverse birth effects, STIs, and cervical cancer. JA99,143,192-93.

Studies show that when specialized family planning clinics are forced to reduce their services, patients lose access to care, and clinics that remain struggle to fill the gap by serving more patients. JA32,101.

II. PROCEDURAL POSTURE

The district court entered a preliminary injunction in favor of Baltimore on May 30, 2019. JA247-74. Defendants filed a notice of appeal and sought a stay of the preliminary injunction from the district court on June 6. JA10-11. The district court denied the stay on June 19, 2019. JA279-82. This Court entered a stay on July 2, 2019. Dkt.23.

ARGUMENT

I. STANDARD OF REVIEW

A party moving for a preliminary injunction must show: (1) likelihood of success on the merits; (2) likelihood of irreparable harm; (3) the balance of equities tips in favor of a preliminary injunction; and (4) a preliminary injunction is in the public interest. *Mountain Valley Pipeline, LLC v. Western Pocahontas Props. Ltd. P'ship*, 918 F.3d 353, 366 (4th Cir. 2019). The court of appeals reviews "factual findings for clear error and legal conclusions *de novo*." *Id.*

II. BALTIMORE IS LIKELY TO SUCCEED ON THE MERITS

A. *Rust*—A *Chevron* Step Two Case—Has No Relevance To Any Questions Presented By This Appeal

The Supreme Court's *Rust* decision is irrelevant to the claims at issue in this appeal. Defendants appear to believe that *Rust* was an omnibus ruling that foreclosed every possible then and future legal claim that could have been or could in the future be brought to challenge HHS's authority to issue a Rule like the 1988 Rule. *See, e.g.*, Br.1 ("Baltimore's challenge to the federal regulation at issue is a transparent attempt to evade the Supreme Court's decision in *Rust*."); Br.13 ("Because *Rust's* reasoning applies with the same force today, the Rule is, at the very least, a permissible exercise of the Secretary's discretion."); Br.22 ("[T]he district court tried to sidestep . . . the Supreme Court's decision in *Rust*."); Br.31 ("[T]he [district] court concluded that Congress abrogated a high-profile Supreme Court decision; after it had tried and failed to do so expressly; in a clause that does not mention . . . *Rust*"); Br.36 ("[T]he district court's theory that the referral restrictions violate § 1554 is substantively the same as the constitutional arguments rejected in *Rust*.").

Defendants' *Rust* argument is ridiculous. *Rust* had three holdings. *First*, *Rust* held that under *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 843 (1984), the 1988 Rule was a permissible construction of § 1008's "ambiguous" language which "does not speak directly to the issues of counseling, referral, advocacy, or program integrity." 500 U.S. at 184. *Second*, *Rust* held that the 1988 Rule did not violate the First Amendment under the Court's interpretation at the time. *Id.* at 192-200. *Third*, *Rust* held that the 1988 Rule did not facially violate the Fifth Amendment by unlawfully restricting access to abortion. *Id.* at 201-03.

Rust did not involve a challenge to the Rule under the Nondirective Mandate or the Non-Interference Mandate. Nor could it have: Congress enacted both years *after* the decision in *Rust*. Rather, the *Rust* Court "agree[d] with every court to have addressed the issue that the language [of § 1008] is ambiguous." *Id.* at 184. And in 1991, the legislative history of the section was also "ambiguous and unenlightening" such that the Court was willing to defer to HHS's "permissible construction of the statute." *Id.* at 186-87. In other words, *Rust* was a *Chevron* "Step Two" case. The Court made no finding that

the 1988 Rule reflected the only or authoritative interpretation of § 1008 or even a *good* interpretation of § 1008. *See id.* And, indeed, the statute has been read differently for almost the entire history of the Title X program.

The present case is controlled by a statutory landscape that Congress put in place *after Rust*, and provisions of the law not raised in *Rust*. As Baltimore has shown, the legislative and regulatory landscape has shifted since *Rust* such that the new Rule is not a permissible interpretation of § 1008. *See FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 143 (2000) ("At the time a statute is enacted, it may have a range of plausible meanings. Over time, however, subsequent acts can shape or focus those meanings.").

Later-enacted and more specific statutes "frequently" modify the meaning of ambiguous earlier statutes. *United States v. Fausto,* 484 U.S. 439, 453 (1988) (per Scalia, J.); *see* Scalia & Garner, Reading Law 330 (2012) ("While the implication of a later enactment will rarely be strong enough to repeal a prior provision, it will often change the meaning that would otherwise be given to an earlier provision that is ambiguous.").

Aware that *Rust* is not really relevant here, Defendants try at various points to repackage their *Rust* argument into an argument that applying the Nondirective and Non-Interference Mandates would transgress (1) the canon against "implied repeals" or (2) the "elephants in mouseholes" canon. *See* Br.2,14,22,27,31,33,38. That is, thankfully, a reduction from the *six* canons of statutory construction Defendants deployed below in arguing that the Court should ignore the two statutes' plain text. But it is still wrong.

In fact, the holding in *Rust* that § 1008 was ambiguous prior to enactment of the Mandates, supports Baltimore's case. The presumption against implied repeals is only triggered when two statutes irreconcilably conflict. *Nat'l Ass'n of Home Builders v. Defs. of Wildlife,* 551 U.S. 644, 662 (2007). "[W]hen two statutes are capable of co-existence," as they are here because of § 1008's ambiguity, "it is the duty of the courts, absent a clearly expressed Congressional intention to the contrary, to regard each as effective." *F.C.C. v. NextWave Pers. Commc'ns Inc.*, 537 U.S. 293, 304 (2003). It is undisputed that the existing regulations, in effect since 1971, reasonably and lawfully interpreted § 1008 and do not violate the Non-Interference and Nondirective Mandates.

In the rulemaking, HHS expressly stated that the Nondirective Mandate *does* affect its regulatory authority under Title X. *See, e.g.*, 84 Fed. Reg. at 7745, 7777. In three other rulemakings HHS has acknowledged that the Non-Interference Mandate limits its regulatory authority as well. *See, e.g.*, 84 Fed. Reg. 23223-24; 83 Fed. Reg. at 57551-52; 83 Fed. Reg. 57608.

The "elephants in mouseholes" doctrine is similarly inapplicable. *See Whitman v. Am. Trucking Associations*, 531 U.S. 457, 468 (2001). The doctrine applies only when a party tries to argue that a "vague" or "ancillary" provision determines an agency's authority. *See id.* But Congress hardly "hid" the two unambiguous restrictions on HHS's authority reflected in the Nondirective and Non-Interference Mandates. One appears in the annual Title X appropriation; the other says that the "the Secretary of Health and Human Services shall not promulgate any regulation" that violates its provisions. And both were considered by HHS in drafting the Rule. *See infra* at 60. These elephants are not hiding in mouseholes—they are hiding in plain sight.

B. The Rule Violates the Nondirective Mandate

Starting in 1996, four years after *Rust*, and in every year since, Congress has included a Title X rider in its appropriations acts. *E.g.*, Pub. L. No. 104-134, 110 Stat. 1321-221 (1996). In the rider, Congress mandates "that all pregnancy counseling shall be nondirective." *Id.*

1. The Rule's bar on abortion referrals, and its requirement of prenatal referrals, each violate the Nondirective Mandate. Defendants' argument that the Rule's bar on abortion referrals does not violate the mandate because barring abortion referrals "does not *direct* the patient to do anything," Br.23, relies on a distortion of the meaning of the medical concept of "nondirective counseling." HHS described nondirective counseling in the Rule itself as follows:

> Nondirective pregnancy counseling is the meaningful presentation of options where the physician or advanced practice provider (APP) is "not suggesting or advising one option over another." . . . Nondirective counseling does not mean that the counselor is uninvolved in the process or that counseling and education offer no guidance, but instead that clients take an active role in processing their experiences and identifying the direction of the interaction. In nondirective counseling, the Title X physicians and APPs promote the client's self-awareness and empower the client to be informed about a range of options, consistent with the client's expressed need and with the statutory and regulatory requirements governing the Title X program.

84 Fed. Reg. 7716. That accords with the generally accepted meaning of nondirective counseling in the medical profession. As Dr. Matthew Wynia, Director of the Center for Bioethics and Humanities at the University of Colorado, explained—

> Non-directive 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, or abortion. Because non-directive counseling is patient directed, a medical professional may elect not to present information on an option if the patient has already indicated she has no interest in pursuing it (with a few limited exceptions such as, for example, in cases of life-threatening conditions). But the basic rule is that a medical professional must present to a patient all relevant therapeutic options, because we are ethically obliged, by virtue of our commitments to both patient welfare and autonomy, not to withhold medically useful information.

JA199. Simply put, there is no basis *anywhere* for the idea that a doctor can withhold medically relevant information and still be engaged in nondirective counseling.

Defendants' argument that forced prenatal referrals are nondirective, Br.23, is equally wrong. A prenatal referral provided not because of the expressed needs of the patient but at the behest of the State is *directive*. It is "suggesting or advising one option over another"

without regard to the patient's wishes. 84 Fed. Reg. 7716. If the patient has expressed that she does *not* want a prenatal referral, then providing one is not merely directive but coercive. *See* 65 Fed. Reg. 41275 ("[R]equiring a referral for prenatal care and delivery or adoption where the client rejected those options would seem coercive and inconsistent with the concerns underlying the 'nondirective' counseling requirement."). Defendants' argument—that prenatal referrals are not directive because they are always medically necessary and because they might not ultimately prevent a woman from obtaining an abortion, Br. 23—are thus not only factually incorrect but entirely beside the point. Counseling is not patient-directed if the content of the counseling is dictated by the government.

Defendants' contrary position is preposterous. Imagine if the Rule mandated abortion referrals, even if a patient indicated she did not want one, and prohibited prenatal referrals, even if a patient indicated she needed one. Imagine HHS stating that abortion referrals are nondirective because abortions are always medically necessary because they are safer than childbirth, and because an abortion referral does not prevent a patient from ultimately seeking out prenatal care. No one

would dispute that such a Rule would be directive in the extreme and a chilling intrusion into the doctor-patient relationship.

For all of the foregoing reasons, the referral list restrictions also violate the Nondirective Mandate. A list, provided in response to a patient request for an abortion referral, on which more than half the providers do not provide abortions and which fails to identify which ones do, does not provide the "meaningful presentation of options" nondirective counseling requires. 84 Fed. Reg. 7716. Nor does it "promote the client's self-awareness and empower the client to be informed about a range of options." *Id.* That the project health care provider cannot tell the patient which of the listed providers actually perform abortions, or that the list omits the most cost-effective and convenient providers, makes it only *more* directive and more inconsistent with the Nondirective Mandate. The list is, by requirement, incomplete, misleading, and directive.

2. Medical referrals are part of medical counseling. "Counseling" is "advice and support that is given to people to help them . . . make important decisions." Merriam-Webster Dictionary Online (2019), http://bit.ly/2X3Dk8z; *see also* Oxford English Dictionary Online (2019),

http://bit.ly/31SgpMi ("the giving of advice"); Black's Law Dictionary (10th ed. 2014) (similar). "Referral" is "the process of directing or redirecting (as a medical case or a patient) to an appropriate specialist or agency for definitive treatment." Merriam-Webster Dictionary Online (2019), http://bit.ly/2RDZjwZ; *see also* Oxford English Dictionary Online (2019), http://bit.ly/2Lfzq5r ("[T]he directing of a patient . . . to a consultant or institution for specialist treatment."); Black's Law Dictionary (10th ed. 2014) (similar). Referral is "giving advice to" a patient about where to go for appropriate treatment. It is unequivocally and necessarily a type of counseling.

Congress has shown that it understands referrals to be part of counseling. A different provision of the Public Health Service Act, 42 U.S.C. § 254c-6(a)(1)—which appears to be the only other instance in which Congress has used the term "nondirective counseling"— mandates that HHS make grants to train staff "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." (emphases added). As that formulation shows, Congress considers "referrals" for other services to be among the "courses of action included

in nondirective counseling."[2] Because "a legislative body generally uses a particular word with a consistent meaning in a given context," *Erlenbaugh v. United States,* 409 U.S. 239, 243 (1972), "nondirective counseling" should have a consistent meaning in the two statutes, encompassing referrals. If that were not enough, Congress has made clear in several other statutes as well that medical and other professional counseling includes referrals. *See, e.g.*, 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)

[2] Defendant's argument that 42 U.S.C. § 254c-6(a)(1) implicitly excludes adoption referrals from nondirective counseling is both agrammatical and illogical. *See* Br.26-27. Defendants state that 42 U.S.C. § 254c-6(a)(1) treats "providing adoption information and referrals" as outside of nondirective counseling. Br.26-27; 28-29. That is wrong three different ways. First, it conflicts with HHS's own understanding of the provision in the Rule itself, as Defendants concede. *See* Br.27 (citing 84 Fed. Reg. at 7733). Second, it is flatly agrammatical. The statute states that "providing adoption information and referrals" should be treated like "all *other* courses of action included in nondirective counseling." That means that they are two of the "courses of action included in" nondirective counseling. Third, Defendants' reading is illogical. "Providing adoption information" is clearly "counseling." Defendant's reading would exclude "providing adoption information" from "nondirective counseling." Basic application of *noscitur a sociis* shows that Congress therefore also considers "referrals" part of nondirective counseling as well.

(sexual-trauma counseling includes "referral services"); 42 U.S.C. § 3020e-1(b) (pension counseling encompasses "referral"); 20 U.S.C. § 1161k(c)(4)(A) (college counseling includes "referrals to . . . other student services staff"). Given all this, Defendants' claim that "referrals" are *not* "included in nondirective counseling," Br.27, is mystifying.

Moreover, the Rule itself repeatedly characterizes referrals as part of counseling. It acknowledges that Section 254c-6(a)(1) reflects 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 7733 (emphases added); *see also id.* at 7730 (same). The Rule thus provides that "nondirective pregnancy counseling can include . . . referrals to adoption agencies." *Id.* at 7730; *see also id.* at 7733-34 ("Title X providers may provide adoption . . . referral . . . as part of nondirective postconception counseling."). There is no reason to believe—and Defendants do not contend—that somehow referrals for adoption are part of "nondirective counseling" but referrals for abortion are not. Moreover, as early as 1981, HHS defined counseling in its Title X Guidelines to include referrals. *See* U.S. Dep't of Health & Human Servs., *Program Guidelines for Project Grants for Family Planning Servs.*

§8.2 (1981) ("Post-examination counseling should be provided to assure that the client . . . receives appropriate referral for additional services as needed.").

Accepted usage within the medical field also supports the conclusion that "nondirective counseling" includes referrals. *See La. Pub. Serv. Comm'n v. FCC,* 476 U.S. 355, 372 (1986) ("technical terms of art should be interpreted by reference to the trade or industry to which they apply"). The "Pregnancy Testing and Counseling" section of HHS's own guidelines advises providers that, during counseling, "[pregnancy] test results should be presented to the client, followed by a discussion of options *and appropriate referrals."* QFP 13-14. (emphasis added). In addition, the guidelines advise that counseling "should be provided in accordance with recommendations from professional medical associations, such as ACOG [the American College of Obstetricians and Gynecologists] and AAP [the American Academy of Pediatrics]." *Id.* at 14. Each of these organizations explicitly recommends that referrals be provided as part of counseling. JA133. The AMA, likewise, advises that a doctor's failure "to provide any and all appropriate referrals" as part of counseling a patient would be "contrary to the AMA's Code of Medical

Ethics." AMA at 3, HHS-OS-2018-0008-179739, http://bit.ly/2Zexyyi. That accords with common sense: A patient who visits a general practitioner and receives a diagnosis would naturally expect to receive a referral for follow-up care.

Nondirective counseling includes referrals notwithstanding that Congress has expressly protected referrals in some unenacted statutes and in some places in its regulations. Br.25. "[U]nenacted legislation has no interpretative value." *United States v. Cooper*, 962 F.2d 339, 342 (4th Cir. 1992), *abrogated on other grounds by Johnson v. United States*, 529 U.S. 694 (2000). Defendants' reading of the Rule would require Congress to preserve surplusage in every bill it enacts to prevent a future Court from unduly narrowing its plain meaning. The best explanation for Congress's and HHS's decision to frequently pair the word "counseling" with "referrals" is this very case—where an opportunistic HHS seeks to narrow the unambiguous words "nondirective counseling" to exclude referrals. *See, e.g.*, *M'Culloch v. Maryland*, 17 U.S. 316, 420-21 (1819) ("If no other motive for its insertion can be suggested, a sufficient one is found in the desire to remove all doubts.").

HHS's reliance on the 2000 Regulations—as support for the proposition that the Nondirective Mandate does not reach referrals—is equally misplaced. As an initial matter, Defendants quote misleadingly from the 2000 Rule. *Compare, e.g.*, Br.26 (stating that HHS in 2000 described the 1988 Rule as "a permissible interpretation of the statute"), *with* 65 Fed. Reg. 41277 (describing HHS's views of the 1988 Rule *as of 1988*). Despite Defendants' suggestion to the contrary, Br.26, HHS never discussed in the 2000 Rule whether the Nondirective Mandate requires nondirective referrals. That is because HHS had already determined that the 1988 Rule was medically and ethically unsupportable, and therefore had no occasion to reach the question whether the Nondirective Mandate compelled its repeal. *See* 65 Fed. Reg. 41271-77. That "HHS never concluded" in the 2000 Rule that the Nondirective Mandate "required suspension of the 1988 regulations," *see* Br.26, is irrelevant.

3. Pregnancy counseling that favors or disfavors one medical option over others violates the Nondirective Mandate. Nondirective counseling must be "neutral." As HHS stated in the Rule itself:

> Title X projects and service providers must be careful that nondirective counseling related to abortion does not diverge from providing neutral, nondirective information . . . .

84 Fed. Reg. 7746; *accord* JA199 (nondirective counseling is "neutral and unbiased"). Defendants' argument that "nondirective counseling does not require 'equal' treatment between childbirth and abortions," Br.29-30, conflicts with HHS's own understanding, and that of the medical community, of what nondirective counseling is.

4. Finally, as discussed above, *supra* at 45-46, the Nondirective Mandate neither impliedly repeals Title X or *Rust*, nor implicates the "elephants in mouseholes" doctrine. Defendants contrary arguments, Br.30-31, are simply incorrect.

Further, Defendants' revisionist history of the Nondirective Mandate is not only wrong but wildly implausible. Br.31-32. Congress enacted the Nondirective Mandate at a time when Title X already required nondirective counseling. Nonetheless, Defendants argue that Congress enacted the Nondirective Mandate to combat "widespread abuse" of that nondirective counseling requirement, Br.31-32, even though there was no evidence of such widespread abuse. Defendants' argument is incoherent. It would make no sense for Congress to enact a requirement that was already part of existing law but expect it to operate differently. Defendants' theory is that Congress enacted a superfluous

statute. The better reading is that Congress enacted the Nondirective Mandate to do exactly what it does: prohibit HHS from permitting directive counseling in the Title X program going forward. Indeed, the best reading of the legislative history is that Congress enacted the Mandate to lock in the then-existing regulation (which already provided for nondirective counseling), as multiple Congress members made clear during the debate on the Mandate. *See, e.g.*, 141 Cong. Rec. 21637 (1995) (statement of Rep. Smith.); *id.* at 21638 (statement of Rep. Porter).

C. The Rule Violates the Non-Interference Mandate

The Rule violates every provision of the Non-Interference Mandate. It erects unreasonable barriers to care, impedes timely access to care, interferes with the provision of relevant medical information to patients, and requires doctors to violate medical ethics. *See* 42 U.S.C. § 18114.

1.a. The Non-Interference Mandate argument is not waived. An issue is preserved if the agency had an opportunity to address it in the rulemaking, *see 1000 Friends of Maryland v. Browner*, 265 F.3d 216, 228 (4th Cir. 2001), as Defendants did here. Commenters need not raise an issue using precise legal formulations—raising the issue "implicitly" is enough. *See id.* at 228.

That standard is amply met here. *See California v. Azar*, No. 19-CV-01184-EMC, -- F. Supp. 3d --, 2019 WL 1877392, at *19-21 (N.D. Cal. Apr. 26, 2019) (discussing waiver and collecting relevant comments). Commenters told HHS that HHS lacked statutory authority to promulgate the Rule. *See, e.g.*, HHS-OS-2018-0008-69480, http://bit.ly/2XVzLBN ("The Department has no statutory authority to dictate medical discussions between providers and patients, nor to dictate or require specific plans of care.").

Commenters also told HHS that the Rule would erect unreasonable barriers to care, impede timely access to care, interfere with doctor-patient communications, deny patients access to medically relevant information, and require doctors to violate medical ethics. *See, e.g.*, HHS-OS-2018-0008-30266, http://bit.ly/2Xl8Han (barriers); HHS-OS-2018-0008-198615, http://bit.ly/2VJantI (barriers); HHS-OS-2018-0008-179339, http://bit.ly/2ZjlEDt (denies information); HHS-OS-2018-0008-106624, https://bit.ly/2Yd6opK (denies information); HHS-OS-2018-0008-188772, http://bit.ly/2Ul3L3p (unethical).

HHS even acknowledged that it had received many comments objecting that the Rule created barriers to patients' access to care,

interfered with provider-patient communications, and violated principles of medical ethics. *See, e.g.*, 84 Fed. Reg. at 7722-24, 7745.

Moreover, not only are agencies presumed to know the law that governs their conduct, but in this case, HHS explicitly relied upon the Mandate in crafting a Rule that directly contradicts it. The Administrative Record specifically states that "HHS consulted upon" the Non-Interference Mandate, "to develop the draft and final rule," during the rulemaking process. Reply.Add.1, Dkt. 43-1 (noting HHS's Reliance on documents listed in attached); Reply.Add.2-9 (attached listing of documents relied upon including, at Entry 29—the ACA, and at Entry 40—the 1996 Appropriations Act, both of which are reproduced in full in the Administrative Record). HHS also addressed the Non-Interference Mandate in three other recent rulemakings. *See* 84 Fed. Reg. 23223-24; 83 Fed. Reg. at 57551-52; 83 Fed. Reg. 57608. HHS was demonstrably aware of the Non-Interference Mandate during this rulemaking process.

1.b. The Non-Interference Mandate argument is not subject to waiver. As this Court held, "[a] purely legal question that this Court may answer without the benefit of the [agency's] expertise" is not subject to waiver. *Cowpasture River Pres. Ass'n v. Forest Serv.*, 911 F.3d 150, 182

(4th Cir. 2018); *see also Sims v. Apfel*, 530 U.S. 103, 110 (2000) (per Thomas, J.) (waiver may be inappropriate in non-adversarial agency proceedings); *St. Marys Cement v. U.S. E.P.A.*, 782 F.3d 280, 288 (6th Cir. 2015) (per Sutton, J.) (waiver should not apply to significant rulemakings). Here, the only arguments that the Rule does not violate the Non-Interference Mandate are purely legal: (1) that the Mandate would constitute an implied repeal of *Rust*; and (2) that the Mandate does not apply to grant programs. HHS has no expertise relevant to those questions.

1.c. Defendants' citations to out-of-circuit precedents involving distinct factual and legal circumstances are unpersuasive. Br.34-35. It is answer enough to point out that under Defendants' understanding of the waiver doctrine, HHS could promulgate a Rule creating "death panels" that decide on the best course of medical treatment for patients and require doctors to withhold medically relevant information from patients as a means of carrying out the panels' dictates, even if tens of thousands of commenters weighed in to argue that the panels would be illegal because they would violate medical ethics, impose unreasonable barriers to access, and interfere with doctor-patient communications.

Under Defendants' understanding, those arguments would be waived—and HHS's rule would be allowed to stand in perpetuity—if those commenters failed to explicitly reference the Mandate. That cannot be right.

2. The Non-Interference Mandate applies to grant programs. The statute's unambiguous text forecloses the Defendants' argument that it does not. *See* Br.35-36. A regulation can certainly "create[] . . . unreasonable barriers to the ability of individuals to obtain appropriate medical care," "impede[] timely access to health care services," "interfere[] with communications regarding a full range of treatment options between the patient and the provider," "restrict[] the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions" and "violate[] the principles of informed consent and the ethical standards of health care professionals" by denying access to grant funds. 42 U.S.C. § 18114. HHS does not directly regulate the practice of medicine (the States do). Thus, it is unclear what the Non-Inteference Mandate would apply to if it did not control the Secretary's expenditure of funds (and Defendants tellingly do not explain what other types of HHS regulations it would apply to). The

legislative history of the Mandate shows no intent to limit its sweep in the manner Defendants suggest. *See* 156 Cong. Rec. 4198 (2010) (statement of Rep. Pascrell).

3. The Rule violates medical ethics. The American Medical Association advises that a doctor's failure "to provide any and all appropriate referrals" as part of counseling a patient would be "contrary to the AMA's Code of Medical Ethics." AMA at 3, HHS-OS-2018-0008-179739, http://bit.ly/2Zexyyi. Unrebutted testimony from Dr. Wynia, Director of the Center for Bioethics and Humanities at the University of Colorado, has similarly explained the Rule violates medical ethics. JA200. The entirety of HHS's response to the argument that the Rule violates medical ethics was that it "disagrees" that the Rule violates medical ethics. 84 Fed. Reg. at 7724, 7748.

Defendants' counsel here abandon the Rule's reasoning and instead contend that *Rust* would not have upheld a rule that violates medical ethics. Br.36-37. But that is a non-sequitor. The Court in *Rust* did not discuss or analyze medical ethics in reaching its holding; *Rust* does not expressly or even implicitly hold that the 1988 Rule was consistent with medical ethics; and the only opinion in *Rust* that addresses medical

ethics—the dissent—stated that the 1988 Rule required physicians to violate medical ethics. *Rust*, 500 U.S. at 213-14 (Blackmun, J., dissenting).

Nor does Congress's decision to balance doctors' conscience rights through the enactment of conscience-protective statutes make the Rule ethical. Br.37. That HHS argument, too, is a non-sequitor. Congress can enact laws that violate medical ethics if it wishes. Many leading medical organizations in fact take the view that a provider must still counsel and refer for treatment the provider objects to. *See, e.g.*, Maya M. Noronha, *Removing Conscience from Medicine: Turning the Hippocratic Oath into A Hypocrite's Pledge*, 23 Geo. J. Legal Ethics 733, 742 (2010). But Congress's decision to enact conscience laws that strike a different balance between individual conscience and medical ethics does not mean that conscience laws that allow doctors to obstruct patient access to needed care are ethical. And it certainly does not make HHS's decision to prohibit providers from making referrals for needed medical care ethical.

3. Finally, as discussed above, *supra* 45-46, the Non-Interference Mandate neither impliedly repeals Title X or *Rust*, nor implicates the

"elephants in mouseholes" doctrine. Defendants contrary arguments, Br.38, are fundamentally incorrect.

The Non-Interference Mandate's "notwithstanding" clause, as a matter of basic English grammar, does not limit the scope of the Mandate. Br.38. Defendants' argument that a provision that actually broadens the Mandate "implicitly" narrows it is incorrect. Br.38. There is nothing "implicitly" narrowing about a clause that provides that the HHS Secretary "shall not promulgate any regulation that" violates medical ethics "notwithstanding" any other provisions of the ACA. *See* 42 U.S.C. 18114. The "notwithstanding" clause means exactly what it says: that the Non-Interference Mandate should not be understood to be narrowed by any other provisions of the ACA. Therefore, contrary to Defendants' claim, Br.38, it simulatenously applies beyond the ACA and means something different from the other notwithstanding clauses in the ACA.

4. The Rule raises unreasonable barriers to care. HHS has not identified any actual benefits from the Separation Requirement. 84 Fed. Reg. 7765. HHS instead states that the Separation Requirement is designed to "reduce, and potentially eliminate, any confusion—actual or

potential—as to" whether Title X funds are used to fund abortions, and to prevent "intentional and unintentional comingling of resources, activities, and services." *Id.* But HHS provides zero evidence to support its claims that either of those were in fact problems with the existing program (in fact, the 2000 regulation squarely stated these were *not* problems, 65 Fed. Reg. 41272). In contrast—and as HHS knew from comments on the Proposed Rule—many existing providers including Baltimore, Planned Parenthood (which serves 40 percent of Title X patients nationwide), and at least four states will be forced to leave the Title X program because of the Separation Requirement, thus erecting a massive barrier to access to appropriate medical care for millions of Americans. At minimum, the withdrawal of so many Title X providers will "impede[] timely access to health care services." 42 U.S.C. § 18114(2). Moreover, these consequences will unreasonably disrupt care not just for patients who rely on Title X for free or subsidized care, but for all patients served by affected facilities—limiting the patients' information and ability to make informed decisions about their medical care, and impeding or delaying their ability to obtain an abortion.

III. THE REMAINING INJUNCTION FACTORS DECISIVELY FAVOR BALTIMORE

The Rule is likely to cause Baltimore irreparable harm and the balance of equities and public interest tip sharply in Baltimore's favor, as the Court below correctly and persuasively held. As the district court found, Baltimore will be forced to withdraw from Title X should the Rule ultimately take effect. JA270. And other providers throughout Maryland and neighboring States will also withdraw from the Program as a result of the Rule, and their withdrawal will further amplify Baltimore's harms. JA271. Providers that remain in the Program will be forced to provide medical care that eviscerates patient trust and is likely to deter patients from utilitizing needed preventative care and other medical services, further intensifying Baltimore's harms. JA217. Against those extraordinary and irreparable harms, the Government contends—consistent with its speed-at-any-cost approach to the Rule—that it will be irreparably harmed by delay itself. JA272; Br.41-42. Those "harms" are inconsequential, not irreparable, and pale in comparison to Baltimore's harms as the Court below correctly held. *Id*.

IV. THE INJUNCTION WAS OF APPROPRIATE SCOPE

Defendants' arguments regarding the Rule's severability and the injunction's scope are meritless and waived. Br.43-47. In light of the centrality of the Rule's limits on counseling and referrals, and the separation requirements, the Rule is inseverable. *See Cmty. for Creative Non-Violence v. Turner*, 893 F.2d 1387, 1393-94 (D.C. Cir. 1990) (relevant question is whether Rule would have been promulgated absent provision). And Defendants have waived the severability argument by refusing to identify any specific provisions that are lawful and severable with any clarity. *See* Br. 46-47.

The injunction was appropriate and narrow. The court below determined that an injunction covering Title X providers in Maryland would be sufficient to protect Baltimore and its health system from potential irreparable harm arising out of the Rule. JA272-73. The injunction clearly comports with Article III and equitable principles. *See Swann v. Charlotte-Mecklenburg Bd. of Ed.*, 402 U.S. 1, 15-16 (1971); *Bresgal v. Brock*, 843 F.2d 1163, 1170-71 (9th Cir. 1987). If anything, the injunction was not broad enough to remedy all of Baltimore's harms.

CONCLUSION

The Court should affirm the decision below.

July 29, 2019

Respectfully submitted,

s/ *Andrew Tutt*

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing response in opposition to motion for stay pending appeal was filed electronically on July 29, 2019 and will, therefore, be served electronically upon all counsel.

s/ *Andrew Tutt*
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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rules of Appellate Procedure 29(a)(4) and 32(g), the undersigned counsel for appellee certifies that this brief:

1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because this brief contains 12,948 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and (6) because this brief has been prepared using Microsoft Office Word and is set in Century Schoolbook font in a size equivalent to 14 points or larger.

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