IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF OHIO

STATE OF OHIO, STATE OF ALABAMA, STATE OF ARIZONA, STATE OF ARKANSAS, STATE OF FLORIDA, STATE OF KANSAS, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF SOUTH CAROLINA, STATE OF WEST VIRGINIA, *Plaintiffs*, v. XAVIER BECERRA, in his official capacity as Secretary of Health and Human Services; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; JESSICA S. MARCELLA, in her official capacity as Deputy Assistant Secretary for Population Affairs; and OFFICE OF POPULATION AFFAIRS, *Defendants*.	:	Case No. 1:21-cv-675

COMBINED MOTION FOR A PRELIMINARY INJUNCTION AND MEMORANDUM IN SUPPORT OF THE MOTION

MOTION FOR A PRELIMINARY INJUNCTION

The Final Rule, *Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services*, 86 Fed. Reg. 56144-01 (Oct. 7, 2021) (to be codified at 42 C.F.R. pt. 59), unlawfully permits funds appropriated under Title X of the Public Health Service Act to be used in programs where abortion is a method of family planning. 42 U.S.C. §300a-6. The plaintiff States move under Federal Rule of Civil Procedure 65 for an order preliminarily enjoining the defendants from implementing or enforcing the Final Rule. This relief is justified for the reasons discussed in more detail in the attached memorandum.

The States respectfully request a ruling on this motion as soon as practicable, and no later than **December 31, 2021.**

Dated: October 25, 2021

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Section 1008 of Title X broadly prohibits Title X funds from being "used in programs where abortion is a method of family planning." 42 U.S.C. §300a-6. Even HHS, in the Final Rule, recognized that Section 1008 "prohibit[s]" the agency from "subsidiz[ing] abortion." 86 Fed. Reg. at 56150 (Oct. 7, 2021). Yet, the Final Rule violates this prohibition in two respects. *First*, it eliminates the 2019 Rule's strict financial- and physical-separation requirements, replacing them with rules that permit a significant degree of financial and physical overlap between Title X programs and programs that provide abortions as a method of family planning. Because "[m]oney is fungible," *Holder v. Humanitarian Law Project*, 561 U.S. 1, 31 (2010), this degree of intermingling guarantees that Title X funds will be used, illegally, to subsidize abortion. *Second*, the Final Rule requires Title X grantees to make referrals for elective abortions "upon request." 86 Fed. Reg. at 56179 (to be codified at 42 C.F.R. §59.5). A program that refers patients for abortions is a program "where abortion is a method of family planning." By requiring that Title X grantees provide abortion referrals, the Final Rule requires these programs to violate Section 1008's prohibition on using Title X funds in programs where abortion is a method of family planning.

None of HHS's anticipatory responses overcome the conflict with the statute. For example, the Final Rule stresses that HHS has taken a similar approach to referrals, and to financial and physical separation, in years past. 86 Fed. Reg. at 56149–50. That is irrelevant; the "magnitude of a legal wrong is no reason to perpetuate it." *McGirt v. Oklahoma*, 140 S. Ct. 2452, 2480 (2020). Nor does it matter that the Supreme Court has described Section 1008 as "ambiguous," in the sense that it does not speak explicitly about referrals or physical-and-financial separation. *Rust v. Sullivan*, 500 U.S. 173, 184 (1991). Ambiguous statutes do not empower executive agencies to do whatever they want. Instead, ambiguous statutes (generally) leave the agency with discretion to enforce the statute in any manner consistent with a "permissible construction of the statute." *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 843 (1984). No permissible construction of Section 1008 permits mandating abortion referrals or allowing the degree of intermingling that the Final Rule does. Finally, HHS cannot save the Final Rule from illegality by expressing its "disagree[ment]" with the proposition "that Title X grant funds … are 'fungible.'" 86 Fed. Reg. at 56150. Economic reality, not to mention Supreme Court precedent, *Holder*, 561 U.S. at 31, takes that disagreement off the table.

An "administrative agenc[y]" must "engage in 'reasoned decisionmaking.'" *Michigan v. E.P.A.*, 576 U.S. 743, 750 (2015) (citation omitted). "Not only must an agency's decreed result be within the scope of its lawful authority, but the process by which it reaches that result must be logical and rational." *Id.* (citation omitted). An agency will be held not to have engaged in reasoned decisionmaking—its rules will be deemed "arbitrary and capricious"—if it "relied on factors which Congress had not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Nat'l Ass'n of Home Builders v. Defs. of Wildlife*, 551 U.S. 644, 658 (2007) (quoting *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983)). "When

an agency changes its existing position," it must "show that there are good reasons for the new policy." *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125–26 (2016) (quotation omitted). And it must consider any "reliance interests" that its previous position "engendered." *Dep't of Homeland Sec. v. Regents of Univ. of Cal.*, 140 S. Ct. 1891, 1913 (2020) (quoting *Encino*, 136 S. Ct. at 2126)). Relatedly, when an agency entirely abandons one position in favor of a drastically different position, it must show that it considered and rationally rejected alternative possibilities. *Id.* at 1912; *State Farm*, 463 U.S. at 47–48.

HHS abandoned the 2019 Rule's strict financial– and physical-separation requirements in favor of an approach that requires no meaningful separation at all. And nothing in the Final Rule shows that HHS considered separation requirements less demanding than the 2019 Rule's requirements but more demanding than the requirements the Final Rule includes. Thus, HHS ignored an "important aspect of the problem," *Michigan*, 576 U.S. at 752, failed to provide "good reasons for the new policy" *Encino*, 136 S. Ct. at 2126, and failed to consider alternative policies, *Regents*, 140 S. Ct. at 1912.

HHS reasoned illogically in determining that the 2019 Rule caused "negative public health consequences." 86 Fed. Reg. at 56150–52. HHS based this conclusion on the supposed fact that participation in the Title X program decreased following the 2019 Rule's promulgation. But, *despite acknowledging* that former grantees who left the program continued providing family-planning services outside the program, 86 Fed. Reg. at 56175, HHS made no effort to determine the number of patients who simply transferred their care from a Title X provider to a non-Title X provider after the 2019 Rule's promulgation. Further, HHS made no effort to account for the positive public-health consequences that the 2019 Rule had. Finally, HHS irrationally failed to account for the pandemic's effect on the ability of new and existing grantees to expand their services following the 2019 Rule.

The Final Rule ignores reliance issues. When large grantees like Planned Parenthood affiliates left the program, other grantees stepped in. Ohio, for example, saw its grant amount nearly double, and it in turn increased funds to new and existing subgrantees. Yet the Final Rule altogether fails to account for the reliance interests that the 2019 Rule "engendered." *Regents*, 140 S. Ct. at 1913 (quoting *Encino*, 136 S. Ct. at 2126). That makes the Final Rule arbitrary and capricious. *Id.*

HHS failed to consider the degree to which eliminating the 2019 Rule's strict financial- and physical-separation requirements would erode public support for the Title X program. Many Americans do not want their tax dollars subsidizing abortion, even indirectly. The Final Rule will subsidize abortion, at least indirectly. And that will erode public support for the program, which will jeopardize the program's success. HHS failed to consider this issue. It thus failed to consider an important aspect of the problem before it, meaning it acted arbitrarily and capriciously. *Michigan*, 576 U.S. at 752.

The referral mandate is arbitrary and capricious in at least four ways. *First*, it rests on the alleged negative public-health effects from the 2019 Rule. But as explained above, HHS's finding of negative public-health effects was arbitrary and capricious. *Second*, HHS failed to consider the effect that mandating referrals would have on public support for the Title X program. *Third*, HHS failed to "show" that there are "good reasons for the new policy." *Encino*, 136 S. Ct. at 2126. The 2019 Rule concluded that, "in most instances when a referral is provided for abortion, that referral necessarily treats abortion as a method of family planning," which Section 1008 bars Title X from subsidizing. 84 Fed. Reg. at 7717. The Final Rule does not even attempt to rebut this. *Fourth*, HHS "entirely failed to consider an important aspect of the problem." *Nat'l Ass'n of Home Builders*, 551 U.S. at 658 (quoting *State Farm*, 463 U.S. at 43). In particular, it failed to consider whether mandating referrals was consistent with medical ethics. And the failure to consider medical ethics in promulgating a Title X rule make that rule arbitrary and capricious. *Mayor of Baltimore v. Azar*, 973 F.3d 258, 276 (4th Cir. 2020) (*en banc*).

The injuries that States will suffer will be *per se* irreparable, as there is no way to recover monetary damages from the defendant officials or from the United States government. And the States will be injured. Among other things, because the Final Rule will enable abortion providers to begin providing Title X services once more, the Final Rule will force the States to compete with these providers for Title X grants. That increased competition for a limited pool of funds constitutes an "actual, here-and-now injury." *Sherley v. Sebelius*, 610 F.3d 69, 74 (D.C. Cir. 2010); *accord Planned Parenthood of Greater Washington v. United States Dep't of Health & Human Servs.*, 946 F.3d 1100, 1108 (9th Cir. 2020).

An injunction now will not substantially harm others. It will simply maintain the *status quo* long enough for this challenge to make its way through the courts, and there is no evidence that third

parties are being *substantially* harmed under the now-existing rules. Further, the public interest favors an injunction, as the public interest is always served by a correct application of the law. *Coal. to Def. Affirmative Action v. Granholm*, 473 F.3d 237, 252 (6th Cir. 2006) (quotation omitted).

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INTRODUCTION

Legislative compromises are one "mark of a healthy society." *Preterm-Cleveland v. McCloud*, 994 F.3d 512, 535 (6th Cir. 2021) (*en banc*) (Sutton, J., concurring). When it comes to abortion, "[f]ederal funding has been the quintessential point of compromise between" two "opposing factions." *Mayor of Baltimore v. Azar*, 973 F.3d 258, 297 (4th Cir. 2020) (*en banc*) (Wilkinson, J., dissenting). One faction consists of the many Americans who believe that abortion entails the taking of an innocent life. The other includes those Americans who believe abortion guarantees "a woman's autonomy to determine her life's course, and thus to enjoy equal citizenship stature." *Gonzales v. Carhart*, 550 U.S. 124, 172 (2007) (Ginsburg, J., dissenting). There is no reconciling these views. Yet, both factions have reached a "compromise" on one issue—funding. The terms of that compromise "have remained quite consistent and clear." *Baltimore*, 973 F.3d at 297 (Wilkinson, J., dissenting). "Congress, on the one hand, does not seek to bar or directly restrain the right established by the Supreme Court in *Roe v. Wade* and its progeny." *Id.* "Congress, on the other hand, seeks to respect those who hold moral or religious objections to the contested practice by withholding federal funds from it." *Id.* "Like all compromises, this one may not be fully acceptable to the heartfelt and passionate views on either side of this debate. But perhaps it is for that very reason that the compromise on federal funding should be respected." *Id.*

Title X of the Public Health Service Act, Pub. L. No. 91-572, §4, 84 Stat. 1504, 1506–08 (1970), reflects this compromise. Title X provides funding for family-planning services. But Congress, in passing the law, included a provision forbidding "funds appropriated under" Title X from being "used in programs where abortion is a method of family planning." 42 U.S.C. §300a-6. The "purpose of singling out this one procedure could only have been Congress's desire not to

subsidize the performance of abortion with the federal fisc." *Baltimore*, 973 F.3d at 296 (Wilkinson, J., dissenting).

The Department of Health and Human Services, "HHS" for short, is not respecting this compromise. In early October, it issued a final administrative rule purporting to implement Title X. *Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services*, 86 Fed. Reg. 56144-01 (Oct. 7, 2021). The "Final Rule," among other things: permits abortion providers to subsidize their abortion practices using Title X dollars; allows Title X grantees to run family-planning programs with an "abortion element," *Provision of Abortion-Related Services in Family Planning Services Projects*, 65 Fed. Reg. 41281-01, 41282 (July 3, 2000) (incorporated into the Final Rule by reference at 86 Fed. Reg. 56150); and *requires* Title X grantees to refer patients for abortions upon request.

The Final Rule, in addition to undermining the "statutory compromise" on which Title X rests, *Baltimore*, 973 F.3d at 297 (Wilkinson, J., dissenting), is illegal. The Administrative Procedure Act requires courts to "hold unlawful and set aside agency action[s]" that are contrary to law or arbitrary and capricious. 5 U.S.C. §706(2)(A). The Final Rule is contrary to law because it permits the use of Title X funds in "programs where abortion is a method of family planning." 42 U.S.C. §300a-6. And the rule is arbitrary and capricious, too, because it did not result from "reasoned decisionmaking." *Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2569 (2019) (citation omitted).

Because the Final Rule will eventually be held unlawful and "set aside," §706(2)(A), and because it will injure the plaintiff States if allowed to go into effect, the States move for a

preliminary injunction. Fed. R. Civ. P. 65. This Court should grant the motion, enjoining HHS from enforcing the Final Rule while this case proceeds.

STATEMENT

1. In 1968, a best-selling book warned that "hundreds of millions of people" would "starve to death" if population growth were not controlled. Paul R. Ehrlich, *The Population Bomb* xi (1968). That concern, which looks silly in retrospect, gained significant traction. President Nixon, in a message to Congress, described population growth as "among the most important issues we face." President Richard Nixon, Special Message to the Congress on Problems of Population Growth (July 18, 1969), https://perma.cc/Z6JF-EA8F. He suggested the government should "provide assistance for more parents in effectively planning their families." *Id.*

Many members of Congress shared the President's concerns. They also worried that poor women and poor families were disproportionately burdened by a lack of access to family-planning services. *See* 116 Cong. Rec. 24091 (July 14, 1970) (statement of Sen. Cranston); 116 Cong. Rec. 40884–85 (Dec. 10, 1970) (statement of Sen. Tydings). To address these concerns, Congress set about enacting a law—Title X—that would assure access to family-planning services. In its final form, Title X makes funding available to grantees who provide these services at reduced cost.

"During the course of the House hearings," there arose "some confusion regarding the nature of the family planning programs envisioned." 116 Cong. Rec. 37375 (Nov. 16, 1970) (statement of Rep. Dingell). In particular, members of Congress wondered whether the bill would "include abortion as a method of family planning." *Id.* In 1970, funding elective abortions would have been incredibly controversial. At that time, the vast majority of States still forbade elective

abortions. Just four States—Alaska, Hawaii, New York, and Washington—had repealed their laws criminalizing abortion. *See Roe v. Wade*, 410 U.S. 113, 140 n.37 (1973).

Title X's supporters in Congress responded by proposing language clarifying that Title X would *not* be used to fund abortion. The as-enacted version of that language appears in Section 1008 of Title X. It provides: "None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning." 42 U.S.C. §300a-6. "With the 'prohibition of abortion' amendment—title X, section 1008—the committee members clearly intend[ed] that abortion is not to be encouraged or promoted in any way through this legislation. Programs which include abortion as a method of family planning are not eligible for funds allocated through this act." 116 Cong. Rec. 37375 (Nov. 16, 1970) (statement of Rep. Dingell). Indeed, "properly operated family planning programs should reduce the incidence of abortion." *Id.* And funding abortion would undermine that goal, since "the prevalence of abortion as a substitute or a back-up for contraceptive methods can reduce the effectiveness of family planning programs." *Id.*

President Nixon signed Title X into law on December 24, 1970. As enacted, Title X empowers the Secretary of Health and Human Services "to make grants to and enter into contracts with public or nonprofit private entities to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services for adolescents)." 42 U.S.C. §300(a). To this day, Section 1008 prohibits Title X funds from being "used in programs where abortion is a method of family planning." 42 U.S.C. §300a-6. Indeed, Congress has bolstered Section 1008: since the 1990s, every bill appropriating Title X funds has made clear that the funds may not be expended on elective abortions, and further

required that "all pregnancy counseling" conducted under Title X "shall be nondirective." *See, e.g.*, Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, Div. H, Tit. V, §506 (2021); Omnibus Consolidated Rescissions and Appropriations Act of 1996, Pub. L. 104-134, tit. II, 110 Stat. 1321, 1321-221 (1996).

2. The initial regulations governing the Title X program essentially reiterated the statutory command: each grantee's application needed to affirm that the "project [would] not provide abortions as a method of family planning." 36 Fed. Reg. 18465-02, 18466 (Sept. 15, 1971). But in 1982, HHS's Office of Inspector General determined that grantees were confused "about precisely what activities were proscribed" by Section 1008 and that this confusion led to "variations in practice by grantees." *Statutory Prohibition on Use of Appropriated Funds in Programs Where Abortion Is a Method of Family Planning*, *Standard of Compliance for Family Planning Services Projects* 52 Fed. Reg. 33210-01, 33210 (Sept. 1, 1987) (proposed rule). The Inspector General's Office suggested clarifying the scope of Title X. In particular, the Office recommended that the Secretary of HHS provide clear guidance on the "scope of the abortion restriction in section 1008." *Id.* at 33210–11 (quotation omitted).

Following this report, HHS proposed "revis[ing] the regulations governing Title X so as to conform the obligations of grantees to the statutory prohibition in section 1008, and to establish standards for compliance with section 1008 that will permit adequate monitoring of such compliance." *Id.* at 33211. These efforts culminated in the "1988 Rule." *Statutory Prohibition on Use of Appropriated Funds in Programs Where Abortion is a Method of Family Planning; Standard of Compliance for Family Planning Services Projects*, 53 Fed. Reg. 2922-01 (Feb. 2, 1988). That rule prohibited Title X projects from promoting, counseling on, or providing referrals for, abortion as a method of

family planning. *Id.* at 2945. The 1988 Rule also required that grantees keep their Title X programs "physically and financially separate" from all prohibited abortion-related activities. *Id.*

The Supreme Court upheld these regulations in *Rust v. Sullivan*, 500 U.S. 173 (1991). But President Clinton suspended the 1988 Rule on his third day in office. *The Title X "Gag Rule,"* 58 Fed. Reg. 7455 (Jan. 22, 1993); *Standards of Compliance for Abortion-Related Services in Family Planning Service Projects,* 58 Fed. Reg. 7462 (Feb. 5, 1993) (interim rule). And eventually, his administration finalized the "2000 Rule." That rule, among other things, required Title X projects to offer and provide pregnant women "information and counseling regarding" their options, including "[p]regnancy termination." *Standards of Compliance for Abortion-Related Services in Family Planning Services Projects,* 65 Fed. Reg. 41270, 41279 (July 3, 2000). And it required Title X grantees to provide a "referral" for abortion "upon request." *Id.* On top of this, the 2000 Rule eliminated the 1988 Rule's strict financial- and physical-separation requirements. *See* 65 Fed. Reg. at 41275–76. Indeed, guidelines published alongside the 2000 Rule confirmed that HHS would permit grantees to integrate their Title X and abortion services to a significant degree. In particular, the guidelines permitted grantees to integrate Title X programs with abortion practices, as long as "the abortion element in a program of family planning services" was not "so large and so intimately related to all aspects of the program as to make it difficult or impossible to separate the eligible and non-eligible items of cost." *Provision of Abortion-Related Services in Family Planning Services Projects*, 65 Fed. Reg. 41281-01, 41292 (July 3, 2000). The guidance then listed permissible *intermingling* of abortion and Title X services, confirming that grantees may operate Title X programs and provide abortions using the same staff and same facilities:

> Certain kinds of shared facilities are permissible, so long as it is possible to distinguish between the Title X supported activities and non-Title X abortion-related

> activities: (a) A common waiting room is permissible, as long as the costs [are] properly pro-rated; (b) common staff is permissible, so long as salaries are properly allocated and all abortion related activities of the staff members are performed in a program which is entirely separate from the Title X project; (c) a hospital offering abortions for family planning purposes and also housing a Title X project is permissible, as long as the abortion activities are sufficiently separate from the Title X project; and (d) maintenance of a single file system for abortion and family planning patients is permissible, so long as costs are properly allocated.

Id.

3. That is where things stood until, in 2019, HHS reinstituted certain provisions of the 1988 Rule so as to better enforce Section 1008's prohibition on the use of Title X funds in programs where abortion is a method of family planning. The 2019 Rule required that Title X projects remain physically and financially separate from any abortion-related activities conducted outside the grant program. *Compliance with Statutory Program Integrity Requirements*, 84 Fed. Reg. 7714-01, 7789 (Mar. 4, 2019). In particular, it stated:

> A Title X project must be organized so that it is physically and financially separate, as determined in accordance with the review established in this section, 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. In order to be physically and financially separate, a Title X project must have an objective integrity and independence from prohibited activities. Mere bookkeeping separation of Title X funds from other monies is not sufficient. The Secretary will determine whether such objective integrity and independence exist based on a review of facts and circumstances. Factors relevant to this determination shall include:
>
> (a) The existence of separate, accurate accounting records;
>
> (b) The degree of separation from facilities (e.g., treatment, consultation, examination and waiting rooms, office entrances and exits, shared phone numbers, email addresses, educational services, and websites) in which prohibited activities occur and the extent of such prohibited activities;
>
> (c) The existence of separate personnel, electronic or paper-based health care records, and workstations; and

> (d) The extent to which signs and other forms of identification of the Title X project are present, and signs and material referencing or promoting abortion are absent.

84 Fed. Reg. at 7789; 42 C.F.R. §59.15 (2019).

In addition to requiring strict financial and physical separation between Title X grantees and abortion services, the 2019 Rule forbade Title X grantees from making abortion referrals. The 2019 Rule, unlike the 1988 Rule, *allowed* nondirective pregnancy counseling by a physician or advanced-practice provider—counseling that might include discussion of abortion. *Id.* at 7788–89. But the rule *prohibited* Title X grantees from making referrals for elective abortions. *Id.*

The 2019 Rule required grantees to comply with most requirements, such as the financial-separation requirement, by July 2019. *Id.* at 7791. But HHS gave grantees more time to comply with the 2019 Rule's *physical-separation* requirement: that requirement would not become effective until March 4, 2020. 84 Fed. Reg. at 7791. Some grantees, including Planned Parenthood, decided to leave the Title X program rather than comply with the new requirements. Sarah McCammon, *Planned Parenthood withdraws from Title X program over Trump abortion rule*, NPR (Aug. 19, 2019), https://perma.cc/L254-VAY8; *see also* 86 Fed. Reg. 19812-01, 19815 (April 15, 2021) (proposed rule). This exodus freed up money that HHS could give to new grantees and to existing grantees willing to expand their services. HHS did just that. Ohio's experience is illustrative. Ohio has long been a Title X grantee; its Department of Health receives Title X grants and then subgrants the money to subgrantees, including county boards of health. Before the 2019 Rule, Planned Parenthood was the only other grantee in Ohio. Once Planned Parenthood left the program, Ohio applied for and received more than $4 million annually in additional Title X funds. It has used that

funding to increase or add to the provision of services in seventeen counties. Decl. of Michelle Clark, attached as Ex. 1 ¶12.

Various individuals, groups, entities, and States challenged the 2019 Rule in courts around the country. The Ninth Circuit upheld the rule. *See California ex rel. Becerra v. Azar*, 950 F.3d 1067, 1074 (9th Cir. 2020) (*en banc*). So did a district court in Maine. *See Fam. Plan. Ass'n of Maine v. United States Dep't of Health & Human Servs.*, 466 F. Supp. 3d 259, 273 (D. Me. 2020). The Fourth Circuit vacated the rule, though only in its application to Maryland. *See Baltimore*, 973 F.3d at 266, 294–95 (majority op.).

The Supreme Court, partly at the request of the federal government, agreed to hear the cases out of the Fourth and Ninth Circuits. *See Oregon v. Cochran*, 141 S. Ct. 1369 (2021). It never got the chance. Apparently to avoid an adverse ruling that might affect its ability to adopt a new rule, the federal government agreed with parties opposed to the 2019 Rule to jointly dismiss the cases—cases that both groups had just recently succeeded in convincing the Supreme Court to hear. *See Oregon v. Becerra*, 141 S. Ct. 2621 (2021). The Court granted that dismissal request over the dissents of Justices Thomas, Alito, and Gorsuch. *Id*.

4. HHS issued a new proposed rule in April. 86 Fed. Reg. 19812-01. In essence, the new rule would replace the 2019 Rule with requirements much like those in place under the 2000 Rule. Ohio and twenty other States submitted comments opposing the proposed rule. *See* Letter to HHS Secretary from Ohio and 20 other States, Ex. 2.

On October 7, HHS published its "Final Rule." 86 Fed. Reg. 56144-01. The Final Rule is, in all relevant respects, identical to the proposed rule. And it does two things of particular relevance here.

First, it eliminates the 2019 Rule's financial- and physical-separation requirements. In place of these requirements, HHS is "reinstating interpretations and policies under section 1008" that were "published" at 65 Fed. Reg. 41281 (July 3, 2000). 86 Fed. Reg. at 56150. Those "interpretations and policies" are the 2000-era guidelines discussed above. And they represent a sharp break from the 2019 Rule. Remember, the 2019 Rule ensured that Title X funds would not be used "in programs where abortion is a method of family planning" by requiring a strict financial and physical separation of Title X programs and the provision of abortion services. The reinstated guidelines, in contrast, allow financial and physical integration as long as "the abortion element in a program of family planning services is [not] so large and so intimately related to all aspects of the program as to make it difficult or impossible to separate the eligible and non-eligible items of cost." 65 Fed. Reg. at 41282. The guidance then goes on to address permissible *intermingling* of abortion and Title X services, suggesting the just-discussed standard allows Title X grantees to use their money to fund all but the most explicit subsidizations of abortion procedures. In particular, the reinstated guidelines allow Title X grantees and abortion providers to share "facilities" and use "common staff." *Id*.

Second, the Final Rule requires that Title X grantees make abortion referrals "upon request." 86 Fed. Reg. at 56179 (to be codified at 42 C.F.R. §59.5). This restoration of the referral requirement in the 2000 Rule eliminates the 2019 Rule's *prohibition* on abortion referrals. *See* 84 Fed. Reg. at 7789.

The new rules will go into effect in early November. Grant opportunities for the 2021–2022 year are forecast to become available on October 15 and applications are forecast to be due on

January 5, 2022. Notice of Grant Opportunity for "Family Planning Service Grants," https://grants.gov (search "PA-FPH-22-001") (last updated Oct. 13, 2021).

5. On October 25, 2021, the plaintiff States sued the HHS and various agency officials in this Court. They filed their motion for a preliminary injunction on the same day.

LEGAL STANDARD

The plaintiff States seek to preliminarily enjoin enforcement of the Final Rule. In deciding whether to award a preliminary injunction, courts must balance four factors: "(1) whether the movant has a strong likelihood of success on the merits; (2) whether the movant would suffer irreparable injury without the injunction; (3) whether issuance of the injunction would cause substantial harm to others; and (4) whether the public interest would be served by issuance of the injunction." *City of Pontiac Retired Emps. Ass'n v. Schimmel*, 751 F.3d 427, 430 (6th Cir. 2014) (quotation omitted).

On the merits, the plaintiffs seek relief under the Administrative Procedure Act, which requires that courts "hold unlawful and set aside agency action[s]" that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. §706(2).

JURISDICTION

This Court has jurisdiction to hear the case under 28 U.S.C. §1331. And the States have Article III standing to sue. Plaintiffs have Article III standing if they suffer an injury in fact, fairly traceable to the defendant's conduct, that is likely to be redressed by a favorable ruling. *Spokeo, Inc. v. Robins*, 136 S. Ct. 1540, 1547 (2016). States are "entitled to special solicitude" throughout this analysis. *Massachusetts v. EPA*, 549 U.S. 497, 520 (2007). And as long as one plaintiff has

standing to sue, Article III is satisfied. *See Rumsfeld v. F. for Acad. & Institutional Rts., Inc.*, 547 U.S. 47, 53 n.1 (2006).

The States have made the necessary showing. First, they sustained an injury in fact. The Final Rule allows abortion providers (like Planned Parenthood of Greater Ohio, and Planned Parenthood's affiliates in other States) to reenter the Title X program. That increases the competition that States will face in obtaining Title X grants. That competitive injury is an injury in fact for Article III purposes. *See Planned Parenthood of Greater Washington v. United States Dep't of Health & Human Servs.*, 946 F.3d 1100, 1108 (9th Cir. 2020); *Sherley v. Sebelius*, 610 F.3d 69, 72–74 (D.C. Cir. 2010); *see also Dep't of Commerce*, 139 S. Ct. at 2565. Because the injury is traceable to the Final Rule, and because an injunction would redress the injury, the States have satisfied all three elements of the standing inquiry and have standing to sue.

ARGUMENT

The Court should preliminarily enjoin the Final Rule pending the completion of these proceedings. *First*, Ohio will likely prevail on the merits, both because the Final Rule is contrary to law and because it is arbitrary and capricious. *Second*, because grant applications are due and because grants will be distributed before this case is finally resolved, the States will be irreparably harmed absent an injunction. *Third*, enjoining the rule will not substantially harm others—it will simply maintain the *status quo* pending a final resolution. *Finally*, an injunction is in the public interest, since "the public interest lies in a correct application" of the law and in the will of the people "being effected in accordance with … law." *Coal. to Def. Affirmative Action v. Granholm*, 473 F.3d 237, 252 (6th Cir. 2006) (quotation omitted).

I. The States are likely to prevail on the merits of this challenge under the Administrative Procedure Act.

The Final Rule is contrary to Title X. It is also arbitrary and capricious. As a result, the States are likely to prevail on the merits.

A. The Final Rule is not in accordance with law.

Title X says that its funds may not be used to support abortion, even indirectly. In particular, Section 1008 states: "None of the funds appropriated under" Title X "shall be used in programs where abortion is a method of family planning." 42 U.S.C. §300a-6. This case presents the question whether the Final Rule, by eliminating meaningful financial- and physical-separation requirements and by requiring Title X grantees to provide abortion referrals, violates Section 1008. The answer is "yes." The rule is therefore "not in accordance with law," and must be held "unlawful and set aside" under the Administrative Procedure Act. 5 U.S.C. §706(2)(A).

1. The Final Rule violates Section 1008 by eliminating all meaningful financial- and physical-separation requirements and by mandating referrals for abortion.

Section 1008, as even HHS recognizes, "prohibit[s]" the agency from "subsidiz[ing] abortion." 86 Fed. Reg. at 56150. But the statute does not expressly detail what that prohibition consists of. It "does not," for example, "speak directly to the issues of counseling, referral, advocacy, or program integrity." *Rust*, 500 U.S. at 184. Section 1008 is "ambiguous" in that sense. *Id.* But ambiguous statutes do not empower executive agencies to do whatever they want. Instead, ambiguous statutes (generally) leave the agency with discretion to enforce the statute in any manner consistent with a "permissible construction of the statute." *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 843 (1984).

This case thus presents the question whether the Final Rule rests on a permissible construction of Section 1008. The question is one of first impression in this Court. Further, neither the Supreme Court nor the Sixth Circuit has ever addressed whether Section 1008 permits the degree of financial and physical integration of Title X programs and abortion services that the Final Rule allows. And neither court has ever considered whether Section 1008 can be interpreted to permit mandatory abortion referrals within the Title X program. Instead, the only binding case on the matter says that the statute *can be* permissibly construed to require strict financial and physical separation and to forbid Title X grantees from making referrals. *Rust*, 500 U.S. at 178–80, 184; *accord California*, 950 F.3d at 1084.

Here, the Court need not define with precision the outer bounds of Section 1008. It is sufficient to hold that the Final Rule exceeds those bounds, thereby violating the statute, by requiring *no* meaningful degree of financial and physical separation and by *mandating* abortion referrals.

Financial and physical separation. Consider first the question whether Section 1008 forbids the Final Rule's lax financial- and physical-separation requirements. It does.

The Final Rule eliminates the 2019 Rule's strict financial- and physical-separation requirements. In place of those requirements, the Final Rule "reinstat[es] interpretations and policies under Section 1008 that were in place for much of the program's history." 86 Fed. Reg. at 56150. Those interpretations and policies permit an enormous amount of financial and physical integration. They state that Title X grantees that provide abortion services comply with Section 1008 whenever "the abortion element in a program of family planning services" is not "so large and so intimately related to all aspects of the program as to make it difficult or impossible to separate the eligible and non-eligible items of cost." 65 Fed. Reg. at 41282 (incorporated by reference at 86

Fed. Reg. at 56150). And these interpretations and policies confirm their weakness by listing the "kinds of shared facilities" deemed "permissible":

> (a) A common waiting room is permissible, as long as the costs [are] properly prorated; (b) common staff is permissible, so long as salaries are properly allocated and all abortion related activities of the staff members are performed in a program which is entirely separate from the Title X project; (c) a hospital offering abortions for family planning purposes and also housing a Title X project is permissible, as long as the abortion activities are sufficiently separate from the Title X project; and (d) maintenance of a single file system for abortion and family planning patients is permissible, so long as costs are properly allocated.

Id. Thus, the Final Rule permits a significant degree of integration between Title X programs and abortion services.

No "permissible construction" of Section 1008 allows for the reinstatement of the 2000-era guidelines. For starters, Section 1008 flatly prohibits Title X funds from being "used in programs where abortion is a method of family planning." 42 U.S.C. §300a-6. The Final Rule, however, says that Title X grantees *can* have an "abortion element in a program of family planning services," as long as it is not too "large" or "intimately related" with the Title X program. 65 Fed. Reg. at 41282. So whereas the statute *prohibits* Title X grants from being used in a program where abortion is a method of family planning, the Final Rule *permits* the Title X programs to have an element that provides abortions as a method of family planning. That is an express violation of Section 1008.

The list of "permissible" shared facilities, *id*, makes the violation even more obvious. As an initial matter, when Title X services and abortion services are available in the same physical location, then Title X funds are necessarily used "in a program *where* abortion is a method of family planning." §300a-6 (emphasis added). In any event, even assuming that Section 1008 can be read to allow *some* sharing of physical locations, the 2000-era guidelines permit integration to a degree

that plainly violates Section 1008. Even HHS admits that Section 1008 bars subsidizing abortion with Title X funds. 86 Fed. Reg. at 56150. Rightly so: a program that directly or indirectly subsidizes abortion as a method of family planning is a "program where abortion is a method of family planning." §300a-6. That dooms the Final Rule. Allowing facilities to share "staff," "waiting room[s]," and treatment rooms, as the Final Rule does, *see* 86 Fed. Reg. at 56150 (incorporating 2000 Rule and associated guidance), means Title X funds *will* be used to subsidize abortions. This follows from the fact that "[m]oney is fungible." *Holder v. Humanitarian Law Project*, 561 U.S. 1, 31 (2010). Money's fungibility means that every dollar an abortion provider receives through Title X frees up another dollar that the grantee can use to subsidize abortion. The money saved on items that Title X pays for, for example, might be used to pay the clinic's rent, to hire additional staff, to advertise abortion services, and so on.

HHS, in adopting the 2019 Rule's financial- and physical-separation requirements, acknowledged the importance of money's fungibility. For example, the agency concluded that many opponents of a strict financial and physical separation "confirm[ed]" the need for such separation by insisting "that requiring physical and financial separation would increase the cost for doing business." 84 Fed. Reg. at 7766. As HHS recognized, because money is fungible, integrating Title X programs and abortion services enables abortion providers to "achieve economies of scale"—they can improve the efficiency of their entire operation by supporting any part of it with Title X funds. *Id.* Thus, the integration permitted by the 2000 Rule allowed "Title X funds" to be used in support of "abortion as a method of family planning." *Id.*

Even assuming for argument's sake that HHS could protect against impermissible abortion subsidies without adopting the strict separation requirements set out in the 2019 Rule, the Final

Rule does not adopt any relaxed-yet-still-sufficient safeguards. Instead, it enables abortion providers to achieve economies of scale using Title X funds. This contradicts Section 1008's prohibition on subsidizing abortion. Indeed, it contradicts the entire purpose of Title X. As the Supreme Court recognized in *Rust*, "if one thing is clear from the legislative history" of Title X, "it is that Congress intended that Title X funds be kept separate and distinct from abortion-related activities." 500 U.S. at 191. The Final Rule contravenes that intent, along with the text Congress enacted to carry its purpose into effect.

Mandatory referrals. The Final Rule also violates Section 1008 by requiring grantees to provide information and counseling regarding elective-abortion referrals "upon request." 86 Fed. Reg. at 56179 (to be codified at 42 C.F.R. §59.5).

At the risk of undue repetition, Title X funds may not be "used in programs where abortion is a method of family planning." 42 U.S.C. §300a-6. When a "program[]" is run so as to *require* that grantees make abortion referrals upon request, it qualifies as a program "where abortion is a method of family planning." After all, if providers are *obligated* to give an abortion referral to any Title X patient who seeks an abortion in hopes of controlling her family's size, then the program is one where "abortion" is a "method of family planning."

An example unrelated to abortion illustrates the point. Imagine a state law that subsidizes psychiatrists who agree to provide free-of-charge "psychiatric care" for teenagers. Suppose the law contains the following qualifier: "No money shall be used in a psychiatry program where electroshock therapy is a method of psychiatric care." Now ask the following question: if a psychiatry practice *required* its psychiatrists to make referrals for electroshock therapy upon request, would it be eligible for the funds? Plainly not. After all, a program that requires psychiatrists to make such

referrals would be a "program where electroshock therapy is a method of psychiatric care." The very same logic means that Title X programs in which doctors are required to make elective-abortion referrals upon request are programs where abortion is a method of family planning.

The Final Rule's deficiencies do not stop there. Remember, the Final Rule allows entities to provide abortions and Title X services out of the same facility with shared staff, shared waiting rooms, and so on. *See above* 10; 65 Fed. Reg. at 41282 (incorporated by reference at 86 Fed. Reg. at 56150). In other words, the Final Rule allows abortion providers to offer Title X services. And, because the Final Rule requires Title X grantees to make abortion referrals upon request, it empowers abortion providers to operate Title X programs in which they refer patients for abortions *at their own facilities*. An abortion clinic that refers a patient to itself for an elective abortion runs a "program[] where abortion is a method of family planning." §300a-6. And again, no one would think twice about that conclusion outside the abortion context. Is a dental practice that refers patients to its own doctors for root canals a practice where root canals are a method of dental care? Is an oncology program that refers cancer patients to its own doctors for chemotherapy a program where chemotherapy is a method of cancer treatment? Is a pediatrician's office in which doctors can refer children suspected of having ADHD to an in-office psychiatrist for a possible Ritalin prescription a practice where Ritalin is a method of treating ADHD? The answer to all these questions is "yes." Therefore, a Title X grantee that provides abortion referrals to doctors within the same office is a program where abortion is a method of family planning.

To be clear, the question for present purposes is not whether Title X grantees may be permitted to make abortion referrals in some specific contexts. Instead, the question is whether the Final Rule contradicts Section 1008 by *requiring* that grantees make abortion referrals upon

request. The answer to that narrower question is "yes." Therefore, the mandatory referral policy in the Final Rule is not in accordance with law.

2. HHS tried, but failed, to defend the Final Rule's legality.

The Final Rule's attempts to square its approach with Section 1008 are all unavailing.

It first insists that HHS has taken a similar approach to enforcing Title X for much of the past forty years. 86 Fed. Reg. at 56149–50. That is irrelevant. The "magnitude of a legal wrong is no reason to perpetuate it." *McGirt v. Oklahoma*, 140 S. Ct. 2452, 2480 (2020). The question for this Court is whether the Final Rule rests on a permissible construction of Section 1008. As just shown, it does not.

The Final Rule next points to *Rust v. Sullivan*. 500 U.S. 173. That case, recall, said that Section 1008 does not speak directly to issues like referrals and physical-and-financial separation. *Id.* at 184. On that ground, *Rust* deemed the statute "ambiguous" with respect to these issues. *Id.* It then determined that the 1988 Rule, in mandating strict financial and physical separation and prohibiting abortion referrals, rested on a permissible interpretation of Section 1008. *Id.* at 184–91. As this description shows, *Rust* does not support the Final Rule's legality. While it acknowledges some ambiguity in Section 1008, it *did not* hold that the statute can be read to permit *mandatory* abortion referrals or to permit the Final Rule's incredibly relaxed approach to financial and physical separation.

HHS concludes its defense by claiming to "disagree[] that Title X grant funds … are 'fungible.'" 86 Fed. Reg. at 56150. That is rather like disagreeing that the sun rises in the east. Money is fungible, whether HHS likes it or not. Thus, there must be adequate safeguards to ensure that Title X grants are not used to subsidize abortion. The Final Rule does not include any.

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Because the Final Rule is not in accordance with law, the States will likely prevail in showing that the Final Rule must be held "unlawful and set aside." 5 U.S.C. §706(2).

B. The Final Rule is arbitrary and capricious.

The Administrative Procedure Act requires the vacatur of agency actions that are arbitrary and capricious. 5 U.S.C. §706(2). To avoid having their rules vacated for arbitrariness and capriciousness, "administrative agencies" must "engage in 'reasoned decisionmaking.'" *Michigan v. E.P.A.*, 576 U.S. 743, 750 (2015) (citation omitted). "Not only must an agency's decreed result be within the scope of its lawful authority, but the process by which it reaches that result must be logical and rational." *Id.* (citation omitted). Thus, the agency must give "a satisfactory explanation for its action." *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983); *accord Montgomery Cty., Maryland v. Fed. Commc'ns Comm'n*, 863 F.3d 485, 491 (6th Cir. 2017).

An agency will be held not to have engaged in reasoned decisionmaking if it "relied on factors which Congress had not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Nat'l Ass'n of Home Builders v. Defs. of Wildlife*, 551 U.S. 644, 658 (2007) (quoting *State Farm*, 463 U.S. at 43); *accord Louisville Gas & Elec. Co. v. Fed. Energy Regul. Comm'n*, 988 F.3d 841, 846 (6th Cir. 2021). "When an agency changes its existing position," it must "show that there are good reasons for the new policy." *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125–26 (2016) (quotation omitted). And it must consider any "reliance interests"

that its previous position "engendered." *Dep't of Homeland Sec. v. Regents of Univ. of Cal.*, 140 S. Ct. 1891, 1913 (2020) (quoting *Encino*, 136 S. Ct. at 2126)). Relatedly, when an agency entirely abandons one position in favor of another, it must show that it considered and rationally rejected alternative possibilities. *Id.* at 1912; *State Farm*, 463 U.S. at 47–48.

The Final Rule's approach to financial and physical separation is arbitrary and capricious. So is the Final Rule's requirement that abortion providers make abortion referrals.

1. The Final Rule's abandonment of the 2019 Rule's financial- and physical-separation requirements is arbitrary and capricious.

For at least four reasons, HHS's decision to jettison the 2019 Rule's financial- and physical-separation requirements is arbitrary and capricious.

a. The Final Rule does not adequately keep Title X funds from being used to illegally subsidize abortion.

HHS abandoned the 2019 Rule's financial- and physical-separation requirements. But it did so without adopting any alternative to keep Title X funds from being used to subsidize abortion. It thereby failed to consider an "important aspect of the problem" before it. *Michigan*, 576 U.S. at 752 (quoting *State Farm*, 463 U.S. at 43). To the extent it considered the problem, it failed to "show that there are good reasons for the new policy," *Encino*, 136 S. Ct. at 2126 (quotation omitted), and failed to consider alternative policies, *Regents*, 140 S. Ct. at 1912.

Again, Title X funds cannot be used to subsidize or promote abortion. *See* 42 U.S.C. §300a-6; Consolidated Appropriations Act, 2021, Div. H, Tit. V, §506. The Final Rule acknowledges this. 86 Fed. Reg. at 56150. Yet it abolishes the 2019 Rule's requirement that Title X grantees remain financially and physically separate from abortion providers. In place of the 2019 Rule's separation requirements, the Final Rule "reinstat[es] interpretations and policies under Section

1008 … that were … published in the Federal Register in 2000." 86 Fed. Reg. at 56150 (citing 65 Fed. Reg. 541281). As detailed above, those interpretations and policies permit significant intermingling of Title X resources and abortion resources; Title X grantees cross the line from "permissible" intermingling to impermissible intermingling *only* when "the abortion element in a program of family planning services is so large and so intimately related to all aspects of the program as to make it difficult or impossible to separate the eligible and non-eligible items of cost." 65 Fed. Reg. at 41282.

Assuming for argument's sake that this alternative approach is consistent with Section 1008, *but see above* 14–17, HHS still had to justify its choice of this alternative over other, more-demanding separation requirements. *Regents*, 140 S. Ct. at 1912–13. In other words, HHS had to justify not only its choice to abandon the 2019 Rule's strict financial- and physical-separation requirements, but also its decision to adopt the Final Rule's incredibly relaxed separation requirements as a means for enforcing Section 1008. It did not do so.

HHS's primary rationale is incoherent. It claimed to "disagree[]" with those who noted that "Title X grant funds … are 'fungible.'" 86 Fed. Reg. at 56150. Based on its non-fungibility finding, apparently, the agency saw no need for any requirements beyond the exceptionally lenient qualitative guidelines adopted in 2000. The trouble is, HHS's position is objectively wrong—"[m]oney is fungible," and there can be no disagreement on that point. *Holder*, 561 U.S. at 31.

Perhaps sensing this, the Final Rule contains a backup argument. It explains that HHS reviewed reports involving the Title X program from 1975 to 2021, and found "no evidence of compliance issues regarding [Section 1008] by Title X grantees." 86 Fed. Reg. at 56145. On that

basis, it concluded that the 2019 Rule's strict financial- and physical-separation requirements were unjustified. *Id.*

That reasoning is doubly flawed. *First*, to the extent it proves anything, it proves only that the 2019 Rule imposed more safeguards than necessary—it does not show that the "interpretations and policies" the Final Rule adopts in place of the 2019 Rule, *id.* at 56150, imposed enough safeguards. Yet HHS failed to consider alternative approaches less strict than the 2019 Rule but more strict than the Final Rule's approach. It stated that the 2019 Rule's financial- and physical-separation requirements imposed "greatly increased compliance costs for grantees and oversight costs for the federal government." 86 Fed. Reg. at 56145. And it concluded that, given the absence of proven violations, those increased costs could not be justified. But instead of even *considering* ways to alleviate the compliance burden—"dedicating funds to assist grantees with those costs, providing additional runway for grantees to comply, giving additional guidance to clarify restrictions," "granting targeted exceptions for those Title X programs in need of flexibilities," or even just relaxing the 2019 Rule's separation requirements, States' Letter, Ex. 2 at 9–10—HHS abandoned meaningful separation requirements entirely. HHS thus failed to consider alternatives. "That omission alone renders [the agency's] decision arbitrary and capricious." *Regents*, 140 S. Ct. at 1913.

Second, the absence of "*evidence* of compliance issues" does not imply the absence of compliance issues. 86 Fed. Reg. at 56145 (emphasis added). Remember, only the short-lived 1988 Rule and the 2019 Rule strictly prohibited financial and physical integration. Between the repeal of the 1988 Rule and 2019, HHS permitted a tremendous degree of financial and physical integration between Title X providers and abortion clinics. *See above* 14–15; *see also* 86 Fed. Reg. at 56150

(incorporating guidance from 65 Fed. Reg. 41281). Given the degree of *permitted* integration, it is hard to see how HHS would have detected *impermissible* integration. Just as a city that eliminates its police force cannot infer a decrease in crime based on a decrease in arrests, an agency cannot cite the absence of compliance issues that it had no ability to detect as evidence that there were no such issues. The Final Rule does not meaningfully address this. To be sure, it vaguely alludes to "a variety of mechanisms" used to enforce Section 1008, "such as grant reports, compliance monitoring visits, third-party audits, compliance guidance, and grantee education." 86 Fed. Reg. at 56150. But the fact that these "mechanisms" exist does not mean they work. How does HHS know that they do or will? It never says, and apparently never considered the matter.

The problem is compounded by the fact that, in promulgating the 2019 Rule, HHS cited evidence of compliance issues that the Final Rule never accounts for. In particular, the 2019 Rule recognized: "Commenters' insistence that requiring physical and financial separation would increase the cost for doing business only confirm[ed] the need for such separation," since it showed that Title X grants were used to create efficiencies that supported the provision of abortion. 84 Fed. Reg. at 7766. The Final Rule altogether ignores this issue, further demonstrating its failure to grapple with the fact that, at all times between the 1988 and 2019 Rules, it had few means for uncovering improper subsidization of abortion.

In sum, when HHS replaced the 2019 Rule's financial- and physical-separation requirements with "interpretations and policies" from 2000, it ignored key aspects of the problem before it and failed to justify the new policy it adopted. It thus acted arbitrarily and capriciously. *Michigan*, 576 U.S. at 752; *Encino*, 136 S. Ct. at 2126; *Regents*, 140 S. Ct. at 1913; *see also Ohio v. U.S. EPA*, 798 F.2d 880, 882 (6th Cir. 1986).

b. HHS relied on flawed data and illogical reasoning when it concluded that the 2019 Rule was having "negative public health consequences."

In explaining the decision to abandon the 2019 Rule, including its financial- and physical-separation requirements, HHS claimed that the 2019 Rule caused "negative public health consequences." 86 Fed. Reg. at 56150–52. But its conclusion is not supported by the evidence on which it relied. Indeed, it failed to adequately account for important factors undermining the relevance of the data before it, including the pandemic's effect on elective healthcare visits. It thus acted arbitrarily and capriciously. *See State Farm*, 463 U.S. at 43.

Size of the Title X program. As an initial matter, HHS placed undue emphasis on the size of the Title X program. The agency inferred that, because the Title X program saw a decrease in client and grantee participation following the 2019 Rule's finalization, public health must have suffered. *See* 86 Fed. Reg. at 56151 ("[T]he Title X program provided services to 844,083 fewer clients in 2019 compared to 2018, prior to the implementation of the 2019 rule, approximately a 22 percent decrease."); *id.* at 56147 ("[I]n 2019 compared to 2018, 225,688 fewer clients received oral contraceptives; 49,803 fewer clients received hormonal implants; and 86,008 fewer clients received intrauterine devices (IUDs)."); *id.* at 56151 ("A total of 41 states and two territories saw a decrease in clients served in 2019 compared to 2018.").

The problem with HHS's reasoning is that its conclusion does not follow from its premises: the fact that patients are not receiving care through the Title X program *does not imply* that they are forgoing care altogether. And if they are not forgoing care, the drop in Title X participation does not imply negative public-health consequences.

HHS seemed to recognize the problem. It noted that Planned Parenthood—a large Title X provider before the 2019 Rule—served *more* individuals the year it exited the Title X program in

the 2019 Rule's aftermath than it did the prior year. HHS conceded that "this evidence may suggest that the Title X program impacts quantified elsewhere in this [rule] may largely be associated with transfers." 86 Fed. Reg. at 56174. By "transfers," the Final Rule means that patients of former grantees that left the Title X program may have continued to obtain care from the same entities *outside of* Title X. Instead of attempting to account for this, however, HHS threw up its hands; it excused itself from having to quantify the effect of transfers on public health, noting the "persistent challenges with clearly disaggregating the effects that represent transfers from effects that represent benefits and costs as a result of this final rule." 86 Fed. Reg. at 56175. Apathy is not reasoned analysis.

In addition to failing to account for care that patients received outside Title X, HHS's evidence of negative public-health consequences *inside* the program was insufficient to support the conclusion that the 2019 Rule had negative public-health consequences.

For example, HHS said that the Final Rule would significantly reduce unintended pregnancy. 86 Fed. Reg. at 56172. But it arrived at this conclusion by relying on an impossible-to-credit memorandum prepared by an abortion-lobbying organization. The memorandum estimates that, among women who use contraception, just 4.6 percent of women who use public-health services will become pregnant. The rate for those same women if they were not able to use public-health services? *29.6 percent*—a rate six times higher. Memorandum from Jennifer J. Frost and Lawrence B. Finer, *Unintended pregnancies prevented by publicly funded family planning services: Summary of results and estimation formula* (2017), https://perma.cc/W2HL-9Q72; *see* 86 Fed. Reg. at 56172 & n.16. Those numbers are hard to buy. And so it is perhaps unsurprising that latter figure—29.6 percent—is unsupported. The abortion lobbying organization invented a hypothetical group, and

assumed that many of these hypothetical women would use either no contraception or ineffective contraceptives without access to public-health services. A single study from a biased source resting on unproven assumptions does not support HHS at all. Put differently, HHS cannot cure its use of unsupported assumptions by citing data from a model that *itself* rests on unsupported assumptions.

HHS also alluded to comments (from providers seeking access to federal funds), indicating that providers witnessed patients forgoing certain services due to cost. Even crediting these self-interested statements, however, they do not move the ball. These statements, if true, show that the 2019 Rule caused some negative public-health consequences. But to justify abandoning the policy based on public-health concerns, HHS needed to show that the 2019 Rule was bad for public health *on net*. More precisely, to support replacing the 2019 Rule with the Final Rule, HHS needed to show that, accounting for the negative *and positive* public-health effects of both rules, the Final Rule is better for public health.

HHS never did that. For one thing, it does not appear to have made any attempt to quantify the 2019 Rule's public-health *benefits*. For another, it appears to have ignored the evidence of the public-health harms that the Final Rule threatened. For example, the States, in their comment letter, pointed to data from the Centers for Disease Control and Prevention showing that sexually transmitted diseases reached a record high in 2018. Association of State and Territorial Health Officials, *National STD Trends: Key Information on Sexually Transmitted Diseases for Public Health Leadership* 1 & n.1 (2019), https://perma.cc/G58R-WBEW; *see* States' Letter, Ex. 2 at 7–8 & n.36. That occurred under the 2000 Rule that the Final Rule effectively reimposes. Yet the Final Rule fails to consider whether its previous approach contributed to this rise. It does not consider, for

example, whether providing Title X services through abortion providers might have encouraged riskier sexual behavior that was bad for public health. That was precisely the possibility that one of Title X's supporters recognized when explaining, on the floor of the House, "that the prevalence of abortion as a substitute or a back-up for contraceptive methods can reduce the effectiveness of family planning programs." 116 Cong. Rec. 37375 (Nov. 16, 1970) (statement of Rep. Dingell). Yet HHS considered neither this nor (it appears) any other potential public-health downsides associated with the Final Rule. HHS thus failed to consider an important aspect of the problem before it and failed to support its conclusion with relevant data, which is arbitrary and capricious. *State Farm*, 463 U.S. at 43; *Kentucky Riverkeeper, Inc. v. Rowlette*, 714 F.3d 402, 411 (6th Cir. 2013).

Assumption of static coverage. In finding the 2019 Rule would lead to negative health consequences, HHS also irrationally concluded that the 2019 Rule had *permanently* decreased the number of patients and grantees participating in Title X. In the words of the Final Rule, HHS determined that "the decline in access, clients, and services from 2018 levels will continue until a new rule is in place." 86 Fed. Reg. at 56152.

This conclusion is not supported by reasoned analysis. Evidence shows that existing grantees were willing and capable of increasing services to provide for community needs. When Planned Parenthood of Greater Ohio ceased to accept Title X funds, Ohio stepped in. The Ohio Department of Health expanded Title X services in seventeen counties. *See* Clark Decl., Ex. 1 ¶12. HHS responded that Ohio and other entities failed to completely fill the gap in coverage caused by the 2019 Rule. 86 Fed. Reg. at 56151, 56169. But that hardly justifies assuming that these supposed gaps would be permanent. For one thing, the Final Rule recognizes that, in four States, six

territories, and the District of Columbia, Title X participation *increased* in 2019. *Id.* at 56146. Further, seven States "experienced a meaningful increase in the number of Title X clinics after the 2019 regulatory change." *Id.* at 56171 n.15.

Regardless, the fact that States, localities, and other entities have not *yet* filled any coverage gaps hardly means they never will. The 2019 Rule has been in effect barely more than two years. And for much of that time, a deadly pandemic sapped and redirected government and private resources. To assume that the current state of affairs is likely to continue, HHS would need to credibly attribute any coverage gaps to inability or disinterest rather than to the pandemic.

HHS tried to do so, but to no avail. In particular, it claimed that only 37 percent of the decline in Title X services was due to the pandemic, while 63 percent was due to the 2019 Rule. 86 Fed. Reg. at 56152; *see also* Office of Population Affairs, *Family Planning Annual Report: 2020 National Survey* D-5, (Sept. 2021), https://perma.cc/V7FZ-ZJHA. But this data does not address the relevant question, which is how the pandemic affected the ability of existing providers to expand their services to fill any gaps in coverage. The Family Planning Annual Report, on which the figures are based, purports to calculate the decrease in Title X patient participation attributable to the pandemic at former and existing Title X clinics. It did not address the degree to which the pandemic hindered public and private entities from expanding their services. How many government and private medical clinics were expanding their services or establishing new locations at a time when patients were being advised to stay home, help was hard to find, and the economy was suffering? *See Coronavirus State and Local Fiscal Recovery Funds*, 86 Fed. Reg. 26786, 26786–92 (May 17, 2021). Presumably not many. But the Final Rule never accounts for this. Without doing so, HHS cannot assume that any coverage gaps would have gone unaddressed in the years ahead.

In any event, the calculations rest on a flawed, or at least unsupported, assumption: that none of the grantees who remained in the program after the 2019 Rule saw new or additional users *because of* the 2019 Rule. In arriving at the 37 percent figure, the Final Rule points to Appendix D of the Family Planning Annual Report: 2020 National Survey. *See* https://perma.cc/V7FZ-ZJHA. That Appendix explains the assumptions that the Office of Population Affairs used to derive this figure. Relevant here, the Office first looked to forty grantees who "reported no network changes or impact because of the" 2019 Rule. *Id.* at D-2. Those entities saw user losses of 21 percent between 2018 and 2020. *Id.* at D-4, D-8. Based on this, the Office determined that the grantees who left the program would have also experienced a 21 percent loss from the pandemic if they had remained in the program. *Id.* at D-3, D-5. That, combined with a pandemic-associated drop from grantees who participated in the Title X program sporadically after the 2019 Rule, gave the Office the 37 percent figure. *Id.* at D-5. The problem with this logic is that the 21 percent figure *does not* represent the entire COVID-caused loss to the forty grantees with no network changes. Instead, it includes the *net change* in the number of patients seen by grantees that reported no network changes as a result of the 2019 Rule, which includes the patients who failed to seek care because of COVID-19 *and also* the patients who began using Title X because of the 2019 Rule—for example, patients who wanted family-planning counseling but wanted not to receive it through Planned Parenthood or another abortion provider. That possibility is hardly fanciful. Again, seven diverse States—Colorado, Delaware, Kentucky, North Dakota, New Mexico, Nevada, and Texas—"experienced a meaningful increase in the number of Title X clinics after the 2019 regulatory change." 86 Fed. Reg. at 56171 n.15. The meaningful rise in the number of clinics implies

actual or anticipated increases in demand for Title X services *because of* the 2019 Rule. HHS's analysis fails to account for this.

Because the Final Rule cites coverage gaps without making any sound effort to determine the degree to which the coverage gaps were due to the difficulty of expanding services during a pandemic, and because the Final Rule baselessly assumes that any coverage gaps remaining just two years after the 2019 Rule's issuance would last forever, HHS failed to consider important aspects of the problem before it. It thus acted arbitrarily and capriciously. *State Farm*, 463 U.S. at 43.

c. HHS failed to account for important reliance interests when it promulgated the Final Rule.

The Final Rule completely neglects to consider reliance issues. The 2019 Rule, thanks in part to the financial- and physical-separation recruitments, caused some entities to leave the program. In Ohio, for example, the only non-State grantee—Planned Parenthood of Greater Ohio—left the program instead of complying with the 2019 Rule. As these grantees left, others began expanding their offerings to fill any gaps left by prior grantees. In Ohio, for example, the State's Department of Health met this need, establishing a new or increased presence in seventeen counties. Clark Decl., Ex. 1 ¶12. Filling those gaps required investments. Yet the Final Rule never mentions this. In other words, HHS failed to consider whether its Final Rule upsets reliance interests that grantees formed in light of the 2019 Rule. By failing to "consider" the "reliance interests" that its previous position "engendered," HHS acted arbitrarily and capriciously. *Regents*, 140 S. Ct. at 1913 (quoting *Encino*, 136 S. Ct. at 2126).

d. HHS failed to consider whether abolishing the financial- and physical-separation requirements would reduce public support for Title X.

HHS failed to consider one other important aspect of the question whether to eliminate the 2019 Rule's financial- and physical-separation requirements. In particular, it failed to consider the degree to which eliminating these requirements and replacing them with the 2000-era guidance would erode public support for the Title X program.

As explained at the outset, Title X reflects a compromise: those opposed to abortion agreed to fund family-planning services as long as they could be assured that their money would not go to fund abortion. That decades-old compromise retains its worth today. Many Americans do not want their tax dollars being used to fund abortion. That is why the federal government has long avoided funding abortion. *See Rust*, 500 U.S. at 201–02; *Harris v. McRae*, 448 U.S. 297, 315–17 (1980); *Maher v. Roe*, 432 U.S. 464, 474 (1977); Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, §§613–14, 131 Stat. 135, 372 (2017). And that is why States across the country have enacted laws to keep tax dollars from supporting the practice. *See Planned Parenthood of Greater Ohio v. Hodges*, 917 F.3d 908, 910 (6th Cir. 2019) (*en banc*); *Planned Parenthood of Ind., Inc. v. Comm'r of the Ind. State Dep't of Health*, 699 F.3d 962, 969–70 (7th Cir. 2012); *Planned Parenthood Ariz. Inc. v. Betlach*, 727 F.3d 960, 964 (9th Cir. 2013); *Planned Parenthood of Kan. & Mid-Mo. v. Anderson*, 882 F.3d 1205, 1212–14 (10th Cir. 2018); *Planned Parenthood Ass'n of Utah v. Herbert*, 828 F.3d 1245, 1250 (10th Cir. 2016); *Planned Parenthood of Gulf Coast, Inc. v. Gee*, 862 F.3d 445, 450–52 (5th Cir. 2017).

As these laws show, programs that fund abortion jeopardize the "compromise" that the "political process" has yielded—a compromise that protects the interests of the many people of good faith who hold diametrically opposed positions on the issue of abortion. *Baltimore*, 973 F.3d

at 297 (Wilkinson, J., dissenting). Failing to respect that compromise means jeopardizing public support for the program. And public support matters. When a program loses that support, it is likely to become less effective, either because there will be fewer grantees willing to participate or because Congress will be less eager to provide the necessary funding. The agency failed to address the concern. It thus failed to consider yet another important aspect of the question before it.

2. HHS acted arbitrarily and capriciously by mandating referrals.

HHS's rule requiring referrals for elective abortions is also arbitrary and capricious. There are at least four reasons why.

First, insofar as it rests on the conclusion that the 2019 Rule caused negative public-health effects, its decisionmaking was flawed for the reasons laid out above. *See above* 25–31.

Second, if Title X clinics are making abortion referrals, the program will lose support from those willing to support funding for family-planning services but *unwilling* to fund abortion. *See above* 32–33. HHS's Final Rule never mentions the concern, signaling that it failed to consider an important aspect of the problem before it.

Third, HHS failed to "show that there are good reasons for the new policy." *Encino*, 136 S. Ct. at 2126 (quotation omitted). As HHS recognized in 2019, "in most instances when a referral is provided for abortion, that referral necessarily treats abortion as a method of family planning." 84 Fed. Reg. at 7717. HHS does not explain how its own conclusion from 2019 has been disproven. Nor has it explained how, without a prohibition on abortion referrals, it will ensure that Title X grants are not being used to promote abortion. At most, the agency notes that grantees have experience navigating this line in the past. 86 Fed. Reg. at 56149–50. But as explained above in connection with the financial- and physical-separation requirements, HHS has not shown that it had

the tools in place to detect whether abortion-referring grantees were in fact engaging in taxpayer-funded promotion of abortion. *See above* 23–24. By failing to justify its sudden departure from its determination that Title X providers generally treat abortion as a method of family planning when they make abortion referrals, the agency acted arbitrarily and capriciously. *See Encino*, 136 S. Ct. at 2126.

Finally, and perhaps most importantly, HHS "entirely failed to consider an important aspect of the problem." *Nat'l Ass'n of Home Builders*, 551 U.S. at 658 (quoting *State Farm*, 463 U.S. at 43). In particular, it failed to consider whether mandating referrals was consistent with medical ethics. In its notice of proposed rulemaking, HHS stated that the 2019 Rule's prohibition on referrals was contrary to the "ethical codes of major medical organizations." 86 Fed. Reg. at 19817. The States submitted a comment explaining that it would be irrational to rely on ethical analyses from those organizations, as it is "doubtful," States' Letter, Ex. 2 at 12, that those "major medical organizations" reflect the ethical views of the medical profession as a whole. One of the organizations in question, the American College of Obstetricians and Gynecologists, has even filed briefs defending the practice of eugenic abortion, in which doctors end the lives of unborn children based on their perceived genetic inferiority. *See* Brief for Am. Coll. of OBGYNS, *et al.*, as *Amici Curiae* in Support of Appellees, *Preterm-Cleveland*, 994 F.3d 512 (No. 18-3329). As the States explained, an organization "willing to stand up for eugenics ought not be taken seriously in any discussion of ethics." States' Letter, Ex. 2 at 13. Certainly these organizations should not be presumed, without evidence, to reflect the ethical views of medical providers generally.

More importantly, however, "major medical organizations" do not dictate the ethical rules that bind medical professionals. Instead, States do. And while States are free to accept input from

major medical organizations, States have the final say. That matters here because the Final Rule, by mandating that grantees refer patients for abortion, conflicts with multiple States' ethical standards governing the practice of medicine. *See* Ariz. Rev. Stat. §36-2154(A); Conn. Agencies Regs. §19-13-D54(f); Fla. Stat. §390.0111(8); Id. Code §18-612; Ky. Rev. Stat. §311.800(4); La. Rev. Stat. §40:1061.2; Mont. Code Ann. §50-20-111(2); N.Y. Civil Rights Law §79-i; Ohio Rev. Code §4731.91; Or. Rev. Stat. §435.485; 18 Pa. Cons. Stat. §3213(d); Wis. Stat. §253.09(1).

HHS was aware of this problem—the States' comment letter informed HHS that, as these provisions showed, mandating referrals would *contravene* medical ethics. *See* States' Letter, Ex. 2 at 12–13. Yet, HHS entirely failed to address the problem. Where an agency is aware of laws that may conflict with a proposed rule, and yet fails to address those laws and articulate a satisfactory solution, it acts in an arbitrary and capricious manner. *Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*, 140 S. Ct. 2367, 2384 (2020). And of particular relevance here, a Title X rule that fails to address medical-ethics concerns raised during the rulemaking process is arbitrary and capricious. *See Baltimore*, 973 F.3d at 276 (majority op.). (While the Fourth Circuit wrongly held that HHS gave insufficient consideration to medical ethics in promulgating the 2019 Rule, it correctly recognized that HHS must consider medical ethics. *Id.*) It follows that the Final Rule is arbitrary and capricious.

*

In sum, the Final Rule is arbitrary and capricious *even if* it is not contrary to law. The States, therefore, will likely prevail on the merits.

II. The plaintiff States satisfy the remaining preliminary-injunction factors

The foregoing shows that Ohio will prevail on the merits. Because it can also prove the remaining three preliminary-injunction factors, it is entitled to a preliminary injunction.

A. The States will be irreparably injured without an injunction.

The States will be irreparably harmed without a preliminary injunction. For one thing, the States will be made to compete with abortion providers for grants come January, when the grant-making process begins. (HHS cannot plausibly deny that abortion providers will reenter the program—one of its primary reasons for promulgating the Final Rule is to allow them to do so. *See* 86 Fed. Reg. at 56171.) That increased competition for a limited pool of funds constitutes an "actual, here-and-now injury." *Sherley*, 610 F.3d at 74; *see also Dep't of Commerce*, 139 S. Ct. at 2565; *Planned Parenthood*, 946 F.3d at 1108. The States, after all, will never be able to recover grant money awarded to and expended by the other grantees with whom they are made to compete by the Final Rule. The non-recoverable nature of the injury makes it irreparable. *See, e.g.*, *Tex. Children's Hosp. v. Burwell*, 76 F. Supp. 3d 224, 244 n.7 (D.D.C. 2014); *Performance Unlimited, Inc. v. Questar Pub., Inc.*, 52 F.3d 1373, 1382–83 (6th Cir. 1995).

What is more, at least one of the plaintiff States—Ohio—was able to expand its services *because* abortion providers dropped out of the Title X program. *See* Clark Decl., Ex. 1 ¶12. Because those providers will now reenter the program, the money will be divided among a larger group of grantees. This means that Ohio will receive less money. That will force it to reduce its services (or spend other state money to make up the difference). Being forced to reduce services constitutes irreparable injury. *See, e.g.*, *Tex. Children's Hosp.*, 76 F. Supp. 3d at 242–44. And, Ohio faces reputational damage from being perceived as unable to adequately serve patients who recently

relied on its Title X services. Low-income patients may no longer trust that clinics associated with the Ohio Department of Health will reliably serve their needs.

Finally, with the 2019 Rule in effect, the States will be forced to support abortion by making referrals upon request. Many States, including plaintiff States, have laws designed to withhold the State's imprimatur from the practice of abortion. *See, e.g.*, Ala. Const. , §36.06; Ariz. Rev. Stat. Ann. §35-196.02; Colo. Rev. Stat. Ann. §25.5-3-106; Fla. Stat. Ann. §627.66996(1); La. Rev. Stat. §40:1061.6; Iowa Code Ann. §217.41B; Miss. Code. Ann. §41-41-91; Mich. Comp. Laws Ann. §400.109a; Mo. Ann. Stat. §188.205; Neb. Rev. Stat. Ann. § 71-7606(3); N.C. Gen. Stat. Ann. §143C-6-5.5; Ohio Rev. Code §5101.56; Tex. Health & Safety Code Ann. §32.005; Wis. Stat. Ann. §20.927. By forcing state-supported clinics to make abortion referrals, the Final Rule will undermine that policy. And there is no repairing the damage done—the States cannot sue HHS for monetary damages or otherwise undo the fact that their clinics will have made abortion referrals.

B. Enjoining the Final Rule will not substantially harm others and will promote the public interest.

That leaves only the final two factors. Both support awarding injunctive relief.

First, "issuance of the injunction" will not "cause substantial harm to others." *City of Pontiac*, 751 F.3d at 430. To the contrary, if there are serious doubts about the legality of the Final Rule, it is better to maintain the *status quo*: neither patients nor anyone else will benefit from the confusion that would result if abortion clinics were to enter the Title X program briefly only to leave again once the Final Rule is permanently set aside. That is especially so because there is no indication that anyone is being *substantially* harmed by the current state of affairs. Planned Parenthood, the largest grantee to exit the program, served more patients and provided more services after exiting the program than it did while a part of the program. 86 Fed. Reg. at 56174. So

there is simply no evidence that the American public or abortion providers will be substantially harmed by a preservation of the *status quo*.

Second, the public interest favors issuing an injunction. This follows from the fact that "the public interest lies in a correct application" of the law and the will of the people being effected "in accordance with … law." *Coal. to Def. Affirmative Action*, 473 F.3d at 252. The Final Rule violates the Administrative Procedure Act. So the public interest favors an injunction.

CONCLUSION

The Court should preliminarily enjoin the Final Rule.

Dated: October 25, 2021

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CERTIFICATE OF SERVICE

I hereby certify that on October 25, 2021, a copy of the foregoing was filed electronically. Notice of this filing will be sent to all parties for whom counsel has entered an appearance by operation of the Court's electronic filing system. Parties may access this filing through the Court's system. I further certify that a copy of the foregoing pleading and the Notice of Electronic Filing will be served by ordinary U.S. mail upon all parties for whom counsel has not yet entered an appearance electronically, at the following addresses:

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LOCAL RULE 65.1(B) CERTIFICATION

I hereby certify that on October 25, 2021, I served a copy of the complaint, this motion, and all other filings in this case by email on the defendants' attorney at the following email address:

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Exhibit 1

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF OHIO

STATE OF OHIO, STATE OF ALABAMA, STATE OF ARIZONA, STATE OF ARKANSAS, STATE OF FLORIDA, STATE OF KANSAS, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF SOUTH CAROLINA, STATE OF WEST VIRGINIA,

Plaintiffs,

v.

XAVIER BECERRA, in his official capacity as Secretary of Health and Human Services; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; JESSICA S. MARCELLA, in her official capacity as Deputy Assistant Secretary for Population Affairs; and OFFICE OF POPULATION AFFAIRS,

Defendants.

Case No. 1:21-cv-675

DECLARATION OF MICHELLE CLARK

I, Michelle Clark, make the following Declaration pursuant to 28 U.S.C. §1746, and state that under the penalty of perjury the following is true and correct to the best of my knowledge and belief.

1. I am the Reproductive Health and Wellness Administrator at the Ohio Department of Health.

2. The Ohio Department of Health operates the Reproductive Health & Wellness Program, which comprehensively addresses issues of reproductive health and wellness (including family planning) with a focus on populations in greatest need and identified priorities.

3. The Reproductive Health & Wellness Program is funded through two federal programs—Title X of the Public Health Service Act and the Maternal and Child Health Block Grant—and through state general revenue funds. For fiscal year 2021-2022, the Reproductive Health & Wellness Program received $1.26 million in maternal health block grant funding, and $1.17 million in state funds.

4. Annual Title X grants are awarded to the Ohio Department of Health with a start date of April 1, through March 30 of the following year. The Ohio Department of Health subgrants Title X funds to local service providers participating in the Reproductive Health & Wellness Program.

5. It is my understanding that the U.S. Department of Health and Human Services sets a ceiling for Title X grant totals within each State and the ceiling for the State of Ohio has been $8.8 million. To my knowledge, the U.S. Department of Health and Human Services has not provided the Ohio Department of Health with a

formula for determining the State's ceiling amount.

6. In March 2019, the U.S. Department of Health and Human Services announced grants to two Title X recipients in Ohio for grant year 2019-20: the Ohio Department of Health and Planned Parenthood of Greater Ohio.

7. The Ohio Department of Health was awarded $4.3 million for grant year 2019-2020.

8. Planned Parenthood of Greater Ohio was awarded $4.0 million for grant year 2019-2020.

9. In response to the March 2019 rule, the Ohio Department of Health updated its policies. The Reproductive Health & Wellness Program had provided non-directive all-options counseling as required by a prior rule. Following the March 2019 rule, the Reproductive Health & Wellness Program provides information on pregnancy termination only through a physician or advanced practice provider, when such information is requested.

10. Following Planned Parenthood of Greater Ohio's exit from the Title X program in August 2019, the Ohio Department of Health applied for and received $2 million additional dollars. The Ohio Department of Health received its additional $2 million award in September 2019, bringing its total funding for grant year 2019-2020 to $6.3 million.

11. Before August 2019, Planned Parenthood of Greater Ohio operated 17 Title X clinics.

12. Beginning in November 2019, the Ohio Department of Health used the

$2 million it received in supplemental Title X funding to expand Title X services in 17 additional counties throughout Ohio. Those counties included all counties where Planned Parenthood of Greater Ohio no longer provides Title X services, along with other counties. The Ohio Department of Health provided for the establishment of nine new clinics and expanded services in eight existing clinics.

13. The Ohio Department of Health applied for and received $8.8 million in Title X funding for grant year 2020-2021.

14. The Ohio Department of Health applied for and received $8.8 million in Title X funding for grant year 2021-2022, and an additional $160,000, which was awarded to all grantees, to assist the Ohio Department of Health in preparing the Family Planning Annual Report (FPAR) 2.0, and to expand its use of data to drive continuous improvements in Title X. The Ohio Department of Health awarded funding to 42 sub-recipients and provided services in 58 of the 88 counties in Ohio.

15. The Department of Health and Human Services, Office of the Assistant Secretary for Health, has notified Title X grant recipients that it expects to post two grant opportunities for 2022-2023 Title X awards on October 15, 2021, to receive applications by January 15, 2022. The first opportunity is expected to provide $258 million to 90 grantees, and the second opportunity is expected to provide $45 million to 70 grantees (to expand telehealth services at Title X family planning sites).

16. In 2018 (January 1 through December 31), the Ohio Department of Health serviced 59,602 visits through its Title X program. In 2019, ODH serviced 58,261 visits, and in 2020, ODH serviced 58,442 visits. From January 1 through

September 30 of 2021, ODH has serviced 45,703 visits, an average of about 111 more visits per month than ODH served in 2018.

17. The Ohio Department of Health has been able to serve additional Ohioans and expand the efficacy of its Reproductive Health & Wellness Program through the additional funds provided starting in September 2019.

18. It is my understanding that, should Planned Parenthood of Greater Ohio once again compete for a Title X grant award in the State of Ohio, it is likely that the Ohio Department of Health will receive fewer dollars for the 2022-2023 grant year than it would have as the sole provider of Title X services.

I have read the following, and it is all true and correct.

October 22, 2021
Dated

Michelle Clark, BSN, RN
RHWP Administrator
Ohio Department of Health

Exhibit 2

DAVE YOST
OHIO ATTORNEY GENERAL

Administration
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May 17, 2021

Secretary Xavier Becerra
United States Department of Health and Human Services
Hubert H. Humphrey Building, Room 716G
200 Independence Avenue SW
Washington, DC 20201

Re: Ohio and twenty other States' comments regarding proposed rule RIN 0937-AA11, as set forth in 42 CFR Part 59, 86 Federal Register 19812.

Dear Secretary Becerra:

Ohio and twenty other States submit these comments in opposition to the notice of proposed rulemaking entitled, "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services," set forth at 86 Federal Register 19812 (April 15, 2021), which are meant to implement Title X of the Family Planning Services and Population Research Act of 1970.[1]

I. THE PROPOSED RULE WILL CAUSE THE DEPARTMENT TO SUBSIDIZE ABORTION IN VIOLATION OF TITLE X.

Many Americans regard abortion as the murder of a child. Other Americans disagree—they consider abortion to be among the most important of rights. "Federal funding has been the quintessential point of compromise between the opposing factions in this fraught and volatile area."[2] "The elements of the compromise may vary in their detail, but the overall components of compromise have remained quite consistent and clear."[3] "Congress, on the one hand, does not seek to bar or directly restrain the right established by the Supreme Court in *Roe v. Wade* and its progeny."[4] "Congress, on the other hand, seeks to respect those who hold moral or religious objections to the contested practice by withholding federal funds from it."[5]

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[1] 42 U.S.C. §300 *et seq.*
[2] *Mayor of Balt. v. Azar*, 973 F.3d 258, 297 (4th Cir. 2020) (en banc) (Wilkinson, J., dissenting).
[3] *Id.*
[4] *Id.*
[5] *Id.*; *accord Rust v. Sullivan*, 500 U.S. 173, 201–02 (1991); *Harris v. McRae*, 448 U.S. 297, 315–17 (1980); *Maher v. Roe*, 432 U.S. 464, 474 (1977); Pub. L. No. 115-31, §§ 613–14, 131 Stat. 135, 372 (2017).

Title X reflects this consensus. Congress enacted Title X in 1970, a few years before the U.S. Supreme Court created a national right to abortion. So, while many States had loosened their abortion laws, many others still restricted the practice as a crime, with limited exceptions. The States and citizens taking that view surely would not have supported family-planning funding that even indirectly supported, or stamped a national imprimatur on, a practice they regarded as criminal. That is why Title X's principal sponsor, Congressman John D. Dingell, offered an amendment to his own bill. He explained:

> Mr. Speaker, I support the legislation before this body. I set forth in my extended remarks the reasons why I offered the amendment which prohibited abortion as a method of family planning.... With the "prohibition of abortion" amendment—title X, section 1008—the committee members clearly intend that abortion is not to be encouraged or promoted in any way through this legislation. Programs which include abortion as a method of family planning are not eligible for funds allocated through this act.[6]

That promise—that abortion not be "promoted in any way"—is reflected in 42 U.S.C. §300a-6. That statute prohibits using Title X funds "in programs where abortion is a method of family planning." The Supreme Court, in a decision upholding regulations materially identical to those in the 2019 Rule[7] that the Department now wishes to replace, held that this phrase was ambiguous to at least some extent, as it does not "speak directly to the issues of counseling, referral, advocacy, or program integrity."[8] But the statute's use of the location-focused word "where"—which, in this context, means "at or in the place in which"[9]—makes at least two things clear.

First, and contrary to the Proposed Rule,[10] Title X funds must not be used at facilities that make abortion referrals. A facility that makes an abortion referral because the patient wants to manage the size of her family (rather than because of a medical emergency) is a facility at which abortion is treated as one option for managing the size of one's family. And so every such facility is, quite literally, a "program where"—a program at or in the place in which—"abortion is a method of family planning."[11]

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[6] 116 Cong. Rec. 37375 (1970).
[7] Compliance With Statutory Program Integrity Requirements, 84 Fed. Reg. 7714 (March 4, 2019).
[8] *Rust*, 500 U.S. at 184.
[9] Webster's Third New International Dictionary 2602 (1993).
[10] *See* 86 Fed. Reg. at 19830.
[11] 42 U.S.C. §300a-6.

Second, and also contrary to the Proposed Rule,[12] Title X funds cannot be used to support a family-planning program that is located *in* an abortion-providing facility. Every abortion-providing facility is, by definition, a facility "where abortion is a method of family planning."[13] It follows that every Title X program that shares a physical location with such a facility is a program *where*—a program at or in the location in which—"abortion is a method of family planning."[14]

The Department cannot deviate from the best reading of the text when it does so to circumvent the statutory provision. And its reasons for deviating from the best reading could not be clearer: the Department, knowing that it cannot *expressly* subsidize abortion, plans to do so indirectly by putting Title X services and abortion services in the same place. Courts reviewing administrative actions are "not required to exhibit a naiveté from which ordinary citizens are free."[15] And when the time comes to review this rule, if it is finalized, they will not.

II. THE DEPARTMENT HAS NOT JUSTIFIED THE NEED FOR ANY ALTERATION TO THE TITLE X RULE.

The Proposed Rule is premised on the idea that, in order to have a successful Title X program, the 2019 Rule must be repealed and replaced. The premise is false: the Department has not sufficiently investigated the effects of the 2019 Rule; there is no reason to suspect that Title X can succeed only by stealthily subsidizing the provision of abortions; and much of the support for the Proposed Rule crumbles with the slightest examination.

A. The Department does not have sufficient data to assess the effects of the 2019 Rule.

The Department has tried to justify the Proposed Rule almost exclusively with reference to the purported effects of the 2019 Rule.[16] But the Department does not, and could not conceivably, have data sufficient to support its conclusion that the current rule is inadequate.

The 2019 Rule took several steps to "ensure compliance with, and enhance implementation of, the statutory requirement that none of the funds appropriated for Title X may be used in programs where abortion is a method of family planning and related statutory requirements."[17] For example, the 2019 Rule permits (but does not require) non-directive consulting about the availability of abortion.[18] It also re-

[12] *See* 86 Fed. Reg. at 19818.
[13] 42 U.S.C. §300a-6.
[14] *Id.*
[15] *Dep't of Com. v. New York*, 139 S. Ct. 2551, 2575 (2019).
[16] *See* 84 Fed. Reg. 7714.
[17] *Id.* at 7714.
[18] *Id.* at 7716–17.

quires Title X recipients to maintain strict physical and financial separation between abortion services and programs that spend Title X money.[19] The 2019 Rule says that "to be physically and financially separate, a Title X project must have an objective integrity and independence from prohibited activities. Mere bookkeeping separation of Title X funds from other monies is not sufficient."[20]

The Department claims the 2019 Rule is not working. But how could it know? The 2019 Rule required grantees to comply with most requirements, such as the financial-separation requirement, by July 2019. But it delayed the compliance date for physical separation of abortion services to March 4, 2020. Rather than comply with the updated regulations, some entities—notably Planned Parenthood, which operates more than 600 clinics—left the program entirely before the 2019 Rule was fully implemented. And on the heels of the March 4 implementation date, the COVID-19 pandemic wreaked havoc on the healthcare industry. Not only were clinics forced to end elective procedures, but the many safety-related restrictions in cities across the country created barriers for people seeking family-planning services—barriers having no relation whatsoever to Title X.

Combining the newness of the 2019 Rule with the complications caused by COVID-19 means the data could not possibly be sufficient to conclude that the 2019 Rule is not working. The COVID-19 pandemic is a particularly complicating factor. It interfered with the provision of nearly *all* services, medical and otherwise, in the American economy. Even many elective and non-elective medical procedures having nothing to do with family planning or abortion were delayed.[21] Thus, even if there were some reason to think that Title X services will decline because of the 2019 Rule—and there is not[22]—the Proposed Rule wrongly assumes that any such decline would remain after we emerge from the pandemic and after Title X grantees become experienced in dealing with the now-in-effect 2019 Rule.

The Department made a reasoned decision in 2019 to align the Title X program with the law. Today, the facts are not sufficiently developed to allow for a meaningful assessment of the 2019 Rule's likely effects. But they will be. Given that individuals are just now, in many areas of the country, starting to leave their homes and seek elective services, and given that state budgets and other sources of funding are being replenished, the 2019 Rule will soon be implemented and the Department can compare apples to apples. Ohio requests that the Department study the effects of the 2019 Rule from January 1, 2022, through December 31, 2022, to form a reasoned basis for decision.

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[19] *Id.* at 7763–77; 42 C.F.R. §59.15.
[20] 42 C.F.R. §59.15.
[21] *See Non-Emergent, Elective Medical Services, and Treatment Recommendations*, Centers for Medicare and Medicaid Services (April 7, 2020), https://perma.cc/6FVT-JAPN.
[22] *See below* 5–13.

B. The Proposed Rule incorrectly assumes that linking abortion to family-planning services is critical to a vibrant Title X program.

1. The Proposed Rule does not account for successful programs in the States that have long separated Title X funds and abortion services. Many States administer their own public-health programs without funding abortion providers. And many States administer Title X programs themselves, effectively, without providing or promoting abortions. The Proposed Rule concocts a link between the success of Title X's family-planning mission and the comingling of abortion and Title X funds. In particular, by eliminating the prohibition on providing Title X services in facilities that provide abortion services, the Proposed Rule assumes that Title X can thrive only if abortion providers assist in the distribution of Title X services. But that is wrong.

Most Title X funds support state agencies and county health departments.[23] Many of these public programs provide no elective abortion services, indeed, many operate pursuant to laws that *prohibit* using federal pass-through dollars to indirectly subsidize elective abortion.[24] Yet they are indisputably able to serve the public nonetheless, providing precisely the services that Title X is designed to fund. For example, in Alabama, the State Department of Public Health is the sole Title X grantee.[25] It uses Title X funds to support 80 health centers across the State, all of which are operated by state and local county health departments.[26] These local health centers provide contraceptive services, pelvic exams, screening for STDs, infertility services, and health education. Alabama's 2019 grant award was over $5,000,000, which it used to provide services to roughly one hundred thousand people.[27] Alabama's health centers do not provide abortions. Nor do they share office space with providers that do. Yet those health centers are still able to provide precisely the services that Title X envisions. There is no reason to doubt that this model can work across the country. So there is every reason to doubt whether a successful Title X program requires allowing abortion providers to offer Title X programs—reality shows that States and other grantees can easily separate the services.

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[23] *See Title X Family Planning Directory*, OASH Office of Population Affairs (Mar. 2021), https://perma.cc/8C75-K7XJ; *see also HHS Awards Title X Family Planning Service Grants*, OASH Office of Population Affairs (March 29, 2019), https://perma.cc/VY8D-QH4F.

[24] *See, e.g.*, Ariz. Rev. Stat. Ann. §35-196.02; Colo. Rev. Stat. Ann. §25.5-3-106; La. Rev. Stat. §40:1061.6; Iowa Code Ann. §217.41B; Miss. Code. Ann. §41-41-91; Mich. Comp. Laws Ann. §400.109a; Mo. Ann. Stat. §188.205; N.C. Gen. Stat. Ann. §143C-6-5.5; Ohio Rev. Code §5101.56; Tex. Health & Safety Code Ann. §32.005; Wis. Stat. Ann. §20.927.

[25] *See Title X Family Planning Directory*, OASH Office of Population Affairs (Mar. 2021), https://perma.cc/8C75-K7XJ.

[26] *See id*.

[27] *See HHS Awards Title X Family Planning Service Grants*, OASH Office of Population Affairs (Mar. 29, 2019), https://perma.cc/VY8D-QH4F.

The Proposed Rule entirely fails to explain the successful Title X programs coming from these States, and instead resorts to bald assertions that Title X requires a close connection with abortion services to be successful.

2. The Proposed Rule also assumes that any gaps created by abortion providers who left the Title X program in response to the 2019 Rule will be permanent. That assumption is baseless. It ignores the fact that, when abortion providers like Planned Parenthood left Title X in 2019, other providers stepped in to fill gaps in coverage. Ohio's experience illustrates the point. In Ohio, before the 2019 Rule went into effect, only two grantees received money through the Title X program: Planned Parenthood and the State of Ohio. (The State then subgranted the funds to other entities, including, for example, county boards of health.) In March 2019, Planned Parenthood of Greater Ohio was awarded $4 million, and the Ohio Department of Health was awarded $4.3 million.[28] Once the new rules went into effect, however, Planned Parenthood left the program because it did not wish to comply with the 2019 Rule.[29] That, however, did not leave a gap in coverage. That is because, as the Department knows, it took the funds that Planned Parenthood affiliates relinquished and granted $33.6 million in supplemental funds to Title X grantees. In Ohio, *all* of the funding that would otherwise have gone to Planned Parenthood went to the Ohio Department of Health instead.[30] And Ohio used the new money to expand its provision of Title X services in areas previously served by Planned Parenthood.

What this shows is that there are plenty of actors, including the States themselves, eager to participate in the program envisioned by Title X. (To the extent there are some gaps that remain to be filled, there is no reason to assume those gaps will remain as States and providers emerge from the pandemic and become accustomed to the 2019 Rule.) The Department need not choose between providing Title X services and indirectly supporting abortion: it can have both, by letting entities that do not wish to subsidize abortion provide the services Congress intended.

C. The Proposed Rule does not adequately justify its abandonment of the 2019 Rule.

Perhaps not surprisingly given the dearth of data and the States' long experience showing that the 2019 Rule is perfectly consistent with a successful Title X program, the Proposed Rule contains no adequate justification for jettisoning the now-existing regulations. Worse, the justifications it does give all fail.

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[28] *Id.*

[29] *See California v. Azar,* 950 F.3d 1067, 1099 n.30 (9th Cir. 2020) (*en banc*).

[30] *See HHS Issues Supplemental Grant Awards to Title X Recipients*, OASH Office of Population Affairs (Sept. 30, 2019), https://perma.cc/5XF5-MAER.

1. The Proposed Rule does not adequately identify or explain negative health consequences.

The Proposed Rule attempts to describe "large negative public health consequences" for maintaining the existing Rule.[31] Such consequences are conjecture, and are not supported by the facts in the Proposed Rule. To the extent that the United States in 2019 experienced a decline in Title X services, the Proposed Rule fails to explain likely causes, and thus fails to address those causes in any policy alternatives.

a. As its primary justification, the Proposed Rule explains that fewer Title X services were provided in 2019 than 2018. That is a red herring. That fact speaks only to the size of a federal program, and not to the availability or quality of family-planning services for Americans. The bureaucratic illogic goes like this: the bigger the federal program, the better for Americans. That cannot be the case. If a city has fewer police encounters in a given year, that is likely good thing, indicating less crime. If Medicaid has fewer enrollees, that too may indicate increased health, prosperity, or the fact that the Medicaid-eligible population prefers other options. The relevant question for Title X is not whether the program provided fewer services, but whether Americans' reproductive health is better. The Proposed Rule fails to consider that issue, instead baselessly assuming that bigger is better.

Concerningly, the Proposed Rule assumes that 181,477 unintended pregnancies have resulted from the 2019 Rule, in a single year. The facts do not bear this out. First, the rate of contraception use increased in every State between 2017 and 2019, and many of these methods are long-term or permanent.[32] That increased use would indicate that unintended pregnancies decreased in 2019. Moreover, as the Proposed Rule says, 47 percent of unintended pregnancies result in unplanned births.[33] But the birthrate in 2020 fell to its lowest level in more than 40 years, with the decline occurring across every age and race.[34] The Proposed Rule's justification—that replacing the 2019 Rule is necessary for public health—is built on irrelevant and apparently false information.

In addition, the Proposed Rule speculates that the 2019 Rule threatened public health, but fails to acknowledge, let alone explain, concerning health trends that far pre-date the 2019 Rule. These trends may be continued or accelerated by the resuscitation of the 2000 Rule.[35] For example, in 2018, the Centers for Disease Control

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[31] 86 Fed. Reg. at 19817.
[32] Ayana Douglas-Hall, Naomi Li, & Megan L. Kavanaugh, *State-Level Estimates of Contraceptive Use in the United States, 2019*, Guttmacher Institute (Dec. 2020), https://perma.cc/NRS7-9T4B.
[33] 86 Fed. Reg. at 19823–24.
[34] Brady E. Hamilton et al., *Births: Provisional Data for 2020*, National Center for Health Statistics (May 2021), https://www.cdc.gov/nchs/data/vsrr/vsrr012-508.pdf.
[35] Standards of Compliance for Abortion-Related Services in Family Planning Services Projects, 65 Fed. Reg. 41269 (July 3, 2000).

and Prevention reported that STDs were at a record high.[36] The Proposed Rule does not indicate why it prefers to restore the policy that was in place when America reached this unfortunate peak.

b. The decrease in Title X services is likely explained, in whole or in part, by other causes. The Proposed Rule does not address them.

In simply examining the number of services provided, the Proposed Rule fails to weigh the significance of Planned Parenthood's, and other grantees', exit from the program. They declined Title X funds entirely rather than complying with the 2019 Rule. These decisions may explain most, if not all, of the Title X service reduction. Planned Parenthood served *more* individuals in 2019 than the prior year, further undermining the notion that access to certain services is threatened by the existing rule. For example, the Proposed Rule explains that 90,386 fewer Papanicolaou (Pap) tests were conducted in 2019 than 2018. But Planned Parenthood says that it performed 255,682 Pap tests in fiscal year 2018–2019 and 272,990 tests in fiscal year 2019–2020.[37] These numbers indicate that it is more likely that women continued to get tested, not that fewer Pap tests were performed in the United States—from a health perspective, it does not matter whether women receive tests in or outside of the Title X program. And as discussed above, *even if* there were a dropoff in the use of Title X services after the adoption of the 2019 rule, that alone does not justify assuming the dropoff will remain permanent as new grantees enter the program and as all grantees adjust to the 2019 Rule, all while patients return to something approaching their pre-pandemic lives.

In addition, of the women served through Title X in 2019 using contraception methods, 19 percent used more reliable, either long-acting or permanent, contraceptive methods, reducing the need for annual or more frequent visits.[38] In fact, the number of women using the most effective methods of contraception has increased 50 percent since 2009.[39]

Also, Title X is most commonly used by young, low-income individuals, many of whom are uninsured.[40] In 2019, median household income rose 6.8 percent from 2018.[41] Thus, individuals who previously used Title X services may today use a primary care provider or gynecologist through private insurance. Also, to the extent

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[36] *National STD Trends: Key Information on Sexually Transmitted Diseases for Public Health Leadership*, Association of State and Territorial Health Officials, https://perma.cc/G58R-WBEW.
[37] *See* Planned Parenthood, Annual Report 2018-2019, https://perma.cc/T7U8-U32G; Planned Parenthood, Annual Report 2019-2020, https://perma.cc/9V7W-AAXJ.
[38] Christina Fowler et al., *Family Planning Annual Report: 2019 National Summary*, OASH Office of Population Affairs, at ES-3 (Sept. 2020), https://perma.cc/Z9HF-EHV4.
[39] *Id*. at 30.
[40] *Id*. at 10, 23–24.
[41] Jessica Semega et al., *Income and Poverty in the United States: 2019*, U.S. Census Bureau (Sept. 15, 2020), https://perma.cc/WE7T-Z387.

contraception is continually becoming more common, a young person may today visit her parents' physician or use her parents' insurance, when previously she would have avoided that interaction.

The healthcare market has also recently become more diverse, adding options like One Medical, a membership-based primary care option with more than 500,000 members.[42] Individuals in search of an affordable, non-insurance-based outpatient clinic have new options beyond Title X clinics.

Notably, the number of Title X services has been declining since 2010. The Proposed Rule, following its own logic, must explain why it readopts much of the 2000 Rule as purportedly better than the 2019 Rule, when the 2000 Rule coincided with declining services (and declining health outcomes, too) for a longer period of eight years—without a pandemic.

To be clear, neither the States nor anyone else can say with much confidence *why* the number of services has declined. Nor can the States or anyone else predict with much confidence whether the trend will continue. The 2019 Rule has been in effect for so short a time period, and its effects are complicated by so many variables (including a once-in-a-lifetime pandemic), that everyone needs more time to understand the likely effects of the 2019 Rules. What we do know, however, is that the Department has no basis for assuming that a decrease in the provision of services, which occurred in the midst of a global pandemic and during the transition to a new regulatory scheme, will be permanent, and the Department has no clear evidence of its impact on patient health.

c. Having identified its concerns with the 2019 Rule, the Department asserts that it considered two regulatory alternatives to address them: (1) maintaining the 2019 Rule and adding more grantee oversight; or (2) re-adopting the 2000 Rule and adding even more grantee flexibility. But these alternatives do not actually meet the regulatory goals of the Proposed Rule, exposing that the Department did not actually consider policy alternatives.

The Department purportedly seeks to: (1) mimic the number of services provided during the 2000 Rule, (2) improve public health, and (3) decrease compliance costs for grantees. The Proposed Rule then explains that one alternative would be to "impose additional restrictions on grantees."[43] This is not an alternative means to seek the benefits the Department outlines. If the Department believes that grantee compliance costs are too great, then realistic policy alternatives would include: dedicating funds to assist grantees with those costs, providing additional runway for grantees to comply, giving additional guidance to clarify restrictions, or granting

[42] *One Medical Announces Results for Third Quarter 2020* (Nov. 10, 2020), https://perma.cc/4926-ZJGY.
[43] 86 Fed. Reg. at 19827.

targeted exceptions for those Title X programs in need of flexibilities. The Proposed Rule does not indicate that the Department considered these or any other alternatives for meeting, rather than frustrating, its stated goals.

Incidentally, the second alternative—"reducing programmatic oversight"—is entirely unexplained. It is impossible for the public to contemplate benefits of an alternative void of content.

2. Removing the physical and financial separation requirements will result in the misuse of funds.

The Proposed Rule removes the 2019 Rule's physical and financial separation requirements on the basis that the requirements provide no benefits. But the Department's failure to identify misused grant funds between 1993 and 2019 proves the need for greater, not lesser, oversight. On one hand, the Proposed Rule indicates only that "no diversion" was uncovered "that would justify" increased separation requirements.[44] To the extent the Department *is* aware of funds being diverted during that time, the Proposed Rule fails to explain why such instances do not justify keeping the 2019 Rule. On the other hand, if the Department never uncovered impermissible transfer or commingling of funds between 1993 and 2019, this emphasizes the need for greater separation, recordkeeping, and oversight: it is simply implausible that, during that long period of time, no funds were misused. (To take an analogy, if a State recorded no positive COVID tests in 2020, that would indicate a failure to test correctly, not the absence of disease.)

Moreover, fund diversion or misuse is nowhere defined or explained. At what point does the Department care whether Title X funds and other revenue sources are treated as one pot of funds? May a Title X project and a non-Title X project share rent, even if the services performed under that roof are most commonly abortion services? If a doctor receives half her salary from Title X funds but spends 80 percent of her time performing abortions, is that a permissible or impermissible commingling of funds? The Department must clarify. If the Department believes a grantee can commingle funds without consequence—for example, pay for 99 percent of the salary of an abortion doctor—this scheme violates the statute. If the Department has a line that grantees may or may not cross, the line must not be arbitrary. And if the Department agrees in theory such commingling is impermissible, but in practice fails to enforce the statute, it violates its responsibility to help the President fulfill his constitutional duty to take care that the laws be faithfully executed. In other words, the answer to potential problems with enforcing the statutory mandate is to find *better methods to enforce* that mandate, not to ignore the mandate with a deliberately blind eye.

[44] *Id.* at 19816.

3. The Proposed Rule risks deterring women from seeking family-planning services.

Removal of the 2019 Rule's physical separation requirements could also undermine the Department's purported goals of increasing services and improving public health. For a variety of reasons, many individuals might prefer to receive Title X services at a location that does not also perform abortions. Individuals who believe abortion takes an innocent life likely would not wish to enter a mixed-use Title X facility. Even individuals who are themselves in favor of abortion as a policy matter or who have had abortions in the past might experience discomfort when directly exposed to a vacuum that removes parts of a child in the womb while receiving a Pap test or STD examination.[45] Rather than increase the provision of Title X services, the Proposed Rule is likely to deter individuals from seeking those services in the first place.

4. The Congressional Review Act forecloses the Proposed Rule's misguided attempt to limit State laws governing subrecipients.

Multiple States have laws that restrict state family-planning funding, including federal funding that passes through the State, from being used to pay for abortions.[46] And some States further restrict family-planning funds from organizations that provide abortions, that contract with abortion providers, or that refer patients to get abortions.[47] These laws have permitted these States to operate family-planning services that generate broad public support, and avoid divisive and unproductive fights that may have required some States to eliminate public funding of family-planning services entirely.

In 2016, in the last days of the Obama Administration, the Department published a final rule targeting state laws governing Title X subawards. That rule provided: "No recipient making subawards for the provision of services as part of its Title X project may prohibit an entity from participating for reasons other than its ability to provide Title X services."[48]

But Congress quickly nullified this "Midnight Rule" under the Congressional Review Act.[49] And under the Congressional Review Act, the Department may not reis-

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[45] *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007).
[46] *See, e.g.*, Ariz. Rev. Stat. Ann. §35-196.02; Colo. Rev. Stat. Ann. §25.5-3-106; La. Rev. Stat. §40:1061.6; Iowa Code Ann. §217.41B; Miss. Code. Ann. §41-41-91; Mich. Comp. Laws Ann. §400.109a; Mo. Ann. Stat. §188.205; N.C. Gen. Stat. Ann. §143C-6-5.5; Ohio Rev. Code §5101.56; Tex. Health & Safety Code Ann. §32.005; Wis. Stat. Ann. §20.927.
[47] *See* Ark. Code Ann. §20-16-1602; La. Rev. Stat. §49:200.51; Ind. Code Ann. §5-22-17-5.5; Wis. Stat. Ann. §253.07(5).
[48] 81 Fed. Reg. 91852 (Dec. 19, 2016).
[49] Pub. L. No. 115-23, 131 Stat. 89 (Apr. 13, 2017).

sue the rule in "substantially the same form."[50] The Proposed Rule's invitation for comment regarding "some state policies restricting eligible subrecipients" targets exactly the same state laws as the 2016 Midnight Rule.[51] Thus, any final rule accomplishing what the Proposed Rule suggests may not be issued.

Not only would re-issuing the 2016 Midnight Rule violate the Congressional Review Act, it would also impermissibly intrude on the States' self-governance for no good reason. As explained above, the States have successfully implemented family-planning projects because they are able to maintain a degree of separation from publicly funded abortions, an issue that would garner enormous public outcry and threaten those States' existing programs.

5. The 2019 Rule creates no ethical problems that need to be addressed, but the Proposed Rule will create ethical problems.

The Proposed Rule suggests that it is important to permit abortion referrals and abortion counseling because such referrals and counseling are required by "ethical codes of major medical organizations."[52] But it is of no moment whether most or all medical organizations regard the 2019 Rules as contrary to medical ethics. Indeed, medical organizations represent doctors—the parties *regulated by* rules of medical ethics. While regulated entities are no doubt entitled to their opinions on the rules to which their conduct ought to be subject, the regulators are free to reject those opinions. And to the extent the medical profession as a whole thinks it is unethical to refuse to make an abortion referral, that view is *contrary to* the rules of medical ethics reflected in numerous state and federal laws, which say that doctors *may* refuse to make abortion referrals or otherwise participate in the provision of abortions.[53] The States regulate the ethics of the medical profession; the profession does not simply regulate itself.

Moreover, it is doubtful whether the medical organizations who shared their concerns truly do reflect the views of the medical profession as a whole. Surely they do not represent the views of the American Association of Pro-Life Obstetricians & Gynecologists, or the Christian Medical and Dental Associations.[54] And one of the medical organizations that has expressed concerns with the ban on referrals—the American Association of Obstetricians and Gynecologists—has filed briefs defending

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[50] 5 U.S.C. §801(b)(2).
[51] 86 Fed. Reg. at 19817.
[52] *Id.*
[53] *See, e.g.*, Ariz. Rev. Stat. §36-2154(A); Conn. Agencies Regs. §19-13-D54(f); Fla. Stat. §390.0111(8); Id. Code §18-612; Ky. Rev. Stat. §311.800(4); La. Rev. Stat. §40:1061.2; Mont. Code Ann. §50-20-111(2); N.Y. Civ. Rights Law §79-i; Ohio Rev. Code §4731.91; Or. Rev. Stat. §435.485; 18 Pa. Cons. Stat. §3213(d); Wis. Stat. §253.09(1).
[54] *See* Br. of Amici Curiae Am. Ass'n of Pro-Life OBGYNs, et al., in Support of Petitioners *Azar v. Mayor and City Council of Balt.*, No. 20-454 (U.S., Nov. 9, 2020).

the legality of eugenic abortions.[55] Those willing to stand up for eugenics ought not be taken seriously in any discussion of ethics.

As all this shows, any change to the rules that will require counseling or referrals on abortion will *contradict* medical ethics: as state laws from around the country show, it is unethical to mandate that doctors violate their consciences by endorsing or otherwise participating in abortions.

III. CONSIDERATION OF TECHNICAL CONCERNS.

Several of the definitions in the Proposed Rule are unclear and put grantees in jeopardy of violating federal law.

Clarify "health equity." The Proposed Rule requires applicants to advance health equity. The Proposed Rule does not explain how this requirement differs from existing considerations and requirements in Title X grantmaking. All applicants must already indicate the number of patients served and the extent to which family-planning services are needed locally, and grant priority is given to projects that serve low-income families. In addition, health programs that receive funding from the Department may not discriminate on the basis of race, color, national origin, sex, age, or disability.[56] Thus existing law requires nondiscriminatory treatment, aimed to those patients most in need. To the extent promoting health equity merely reiterates these requirements, such clarification is useful. To the extent promoting health equity differs, and either requires discrimination on the basis of race or should not be aimed at certain patients, such clarification would be necessary though likely contrary to law.

Remove "culturally and linguistically appropriate services." Ohio and the signing States fully support the principle that Title X services should be available to individuals regardless of their culture or language. At the same time, States owe a duty to our citizens to put science and health before any interest in the signaling of virtue. As the Department's existing standards for "culturally and linguistically appropriate services" indicate, the many elements of culture include the "use of traditional healer techniques," "how an individual finds and defines meaning in his life," and "political beliefs."[57] Requiring unique health approaches that differ based on the individual belief system of every American is not only impossible, in many cases, it can also be unwise. For example, obesity, smoking, and drug use are

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[55] See Brief for Am. Coll. of OBGYNs, et al., as Amici Curiae in Support of Appellees, *Preterm-Cleveland v. McCloud*, 994 F.3d 512 (6th Cir. 2021) (No. 18-3329).
[56] 42 U.S.C. §18116.
[57] *National Standards for Culturally & Linguistically Appropriate Services in Health & Health Care*, U.S. Dep't of Health & Human Servs. Office of Minority Health at 139–40 (April 2013), https://perma.cc/F8YE-PJVV.

health and reproductive risks, no matter the culture or language of the patient seeking services.

To the extent certain populations require targeted approaches to improve health outcomes, that approach is best managed and executed at the state and local level. As it exists in the Proposed Rule, the phrase "culturally and linguistically appropriate services" may bless health practices, based on cultural norms, that lead to negative health outcomes. Ohio therefore recommends removing the phrase as a requirement in Title X grants. The States, as always, will remain passionate about providing the care that their citizens need and deserve.

Amend "quality healthcare." Improving the quality of healthcare in America must be a dynamic process, constantly employing new techniques, identifying threats, preserving privacy, expanding comfort, and decreasing waste and inefficiency. This dynamism requires a nimbleness often unattainable by national requirements, which are slow to adopt useful techniques or recognize local problems. Thus "quality healthcare" should be amended as follows: "Quality healthcare is safe, effective, client-centered, timely, efficient, and equitable, with maximum flexibility at the state and local level to establish standards of care."

* * *

In a country of more than 300 million people, no one gets his or her way all the time. Everyone has to compromise a bit. Title X reflects a compromise. It funds services that large numbers of Americans support while withholding that funding from services that large numbers oppose. The Proposed Rule tramples that compromise, by intertwining family-planning services with the divisive issue of publicly funded abortions. The Proposed Rule is not based on the public health, but grantee preference to have freer rein of taxpayer dollars.

Sincerely,

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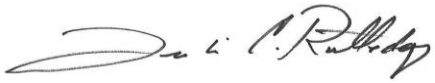

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