No. 19-15974

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff–Appellee,

v.

ALEX AZAR, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES,
Defendants–Appellants.

On Appeal from the United States District Court
for the Northern District of California
No. 3:19-cv-01184-EMC
The Honorable Edward M. Chen, District Judge

ANSWERING BRIEF

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INTRODUCTION

Title X of the Public Health Service Act is the nation's sole federal grant program supporting family planning services for millions of low-income individuals—approximately one million in California alone. For many, especially those living in rural and underserved communities, Title X-funded clinics are the only local providers of critical reproductive and preventive health services.

Earlier this year, the Department of Health and Human Services adopted a new rule that would substantially change its longstanding regulatory regime governing Title X grants in a manner that jeopardizes the care of hundreds of thousands of patients. Among other things, the rule prohibits Title X providers from referring patients for abortion services, even when a woman requests it; requires providers to refer all pregnant women for prenatal care, even when a woman has made clear her intention to terminate the pregnancy; and prohibits providers from even identifying to patients specialized reproductive care clinics. As the district court found, many Title X providers will leave the program rather than comply with these conditions that violate their obligations to their patients, leaving many patients without access to care.

Facing an unintended pregnancy, Title X patients often seek guidance regarding where they can exercise their constitutional right to obtain an abortion, a time-sensitive medical procedure. Yet the rule is designed to keep these patients in

the dark, ensuring that Title X providers steer patients away from abortion and toward childbirth.

HHS's stated justification for the rule is to implement a "'value judgment favoring childbirth over abortion.'" ER33 (quoting *Rust v. Sullivan*, 500 U.S. 173, 192 (1991)). But as the district court observed, "that value judgment cannot be effectuated in an unlawful manner or in violation of other Congressional directives." *Id.* Here, in two statutes postdating the Supreme Court's opinion in *Rust*, Congress has foreclosed HHS's approach. Since 1996, it has mandated that all Title X pregnancy counseling "shall be nondirective." That language means what it says: Title X counseling may not direct patients toward or away from any option, be it abortion or childbirth. Congress also enacted Section 1554 of the Affordable Care Act, which prohibits the Secretary from promulgating any regulation that (among other things) interferes with provider–patient communications or impedes access to care. Congress has mandated that Title X counseling focus on the patient's preferences, not those of the Executive Branch.

In issuing a preliminary injunction blocking enforcement of the rule in California, the district court concluded that HHS likely violated the Administrative Procedure Act by proceeding in a manner contrary to law, and by failing to adequately explain its abrupt departure from its prior Title X regulations. The district court also made a number of detailed and well-supported factual findings

regarding the extensive, irreparable harm that enforcement of the rule would cause. The court found that it would obstruct and delay patients with pressing health needs; would cause many high-quality providers to leave the Title X program, leaving tens of thousands of patients (or more) without care; would increase the number of unintended pregnancies and result in worse health outcomes; and would cause substantial, non-compensable harm to the State and Title X providers. HHS, in response, identified no cognizable harm that would result from a preliminary injunction temporarily keeping the longstanding prior regulatory regime in place while the courts evaluate whether HHS acted lawfully in adopting its new rule.

Under these circumstances, the district court did not abuse its discretion in preserving the status quo for the time needed to litigate that question. The preliminary injunction should remain in place while this case proceeds.

ISSUES PRESENTED

1. Whether the district court abused its discretion in concluding that HHS's new rule—which prohibits Title X providers from giving any patient a referral to an abortion provider, yet requires that providers refer every patient for prenatal care—likely violates Congress's mandate that all Title X pregnancy counseling "shall be nondirective."

2. Whether the district court abused its discretion in concluding that the rule likely violates Section 1554 of the Affordable Care Act, which prohibits HHS

from promulgating any regulation that (among other things) "impedes timely access to health care services" or "interferes with communications regarding a full range of treatment options between the patient and the provider."

3. Whether the district court abused its discretion in determining that HHS acted arbitrarily and capriciously by promulgating the rule without a reasoned justification.

4. Whether the district court committed clear error in finding that California and the other plaintiffs would suffer irreparable harm were the rule to take effect while this litigation is pending, while HHS would suffer no substantial harm.

5. Whether the district court abused its discretion in concluding that the balance of the equities favored a preliminary injunction.

6. Whether the district court abused its discretion in tailoring the injunction.[1]

STATEMENT OF THE CASE

A. Legal Background

Congress created the Title X program in 1970 to provide support for "voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services." 42 U.S.C. §300(a). Section

[1] California agrees with HHS's statement of jurisdiction. AOB3.

1008 of Title X prohibits the funding of "programs where abortion is a method of family planning." *Id.* §300a-6. HHS initially construed this language to allow Title X providers to provide neutral, unbiased counseling to pregnant women about their options, including referrals to other providers for prenatal care, adoption, or abortion, so long as no program funds were used for abortions. ER8-17; SER40-41, 133; *see also Nat'l Family Planning & Reprod. Health Ass'n, Inc., v. Sullivan*, 979 F.2d 227, 229 (D.C. Cir. 1992) (noting that agency memoranda from the 1970s distinguished between permissible nondirective counseling on abortion and impermissible "directive" counseling). HHS's 1981 regulations required Title X providers to offer pregnant women nondirective options counseling on "pregnancy termination (abortion), prenatal care, and adoption and foster care" followed by referral for these services if requested. 53 Fed. Reg. 2922, 2923 (Feb. 2, 1988).

In 1988, HHS issued new regulations banning Title X programs from providing any type of counseling to pregnant women regarding abortion, including referrals—even in response to a patient request. 42 C.F.R. §59.8(a)(1) (1989). The regulations also instituted strict physical and financial separation between Title X-funded projects and any activities related to abortion outside of the Title X program. *Id*. §59.9. The Supreme Court considered the legality of these 1988 regulations in *Rust v. Sullivan*, 500 U.S. 173 (1991). The Court examined the text and legislative history of Title X and determined that the scope of Section 1008's

prohibition on "abortion [as] a method of family planning" was ambiguous and that Congress had not spoken "directly to the issues of counseling, referral, advocacy, or program integrity." *Rust*, 500 U.S. at 184. The Court afforded *Chevron* deference to HHS's interpretation of Section 1008, concluding, "we are unable to say that the Secretary's construction of the prohibition in §1008 to require a ban on counseling, referral, and advocacy [regarding abortion] within the Title X project is impermissible." *Id*. The Court also upheld the separation requirements and rejected constitutional challenges to the regulations. *Id.* at 187-203.

The 1988 regulations, however, were in effect only for a few months and were never fully implemented. *See* ER15-16; *Nat'l Family Planning*, 979 F.2d at 230. HHS suspended them entirely in 1993, concluding that they "inappropriately restrict[ed] grantees." 58 Fed. Reg. 7462, 7462 (Feb. 5, 1993).

The governing law has not remained static in the decades after *Rust*. Beginning in 1996, Congress has provided additional, specific direction regarding the type of counseling Title X grantees may provide. Since then, in its annual appropriations legislation funding Title X, Congress has mandated that "all pregnancy counseling shall be nondirective." Pub. L. No. 104-134, 110 Stat. 1321, 1321-22 (1996); *see, e.g.*, Pub. L. No. 115-245, Div. B., Tit. II, 132 Stat. 2981, 3070-71 (2018).

In 2000, to help effectuate this new statutory mandate, HHS issued regulations requiring Title X projects to provide pregnant women with "neutral, factual information and nondirective counseling on each of [her] options, and referral on request, except with respect to any option(s) about which the pregnant woman indicates she does not wish to receive such information and counseling." 42 C.F.R. §59.5(a)(5)(ii) (2000); *see* 65 Fed. Reg. 41270, 41281 (July 3, 2000). The 2000 regulations also required Title X providers' abortion activities to be financially "separate and distinct" from their Title X activities, but allowed shared facilities (such as common waiting rooms, common staff, and a single filing system) so long as costs were properly separated and it was "possible to distinguish between the Title X supported activities and non-Title X abortion-related activities." 65 Fed. Reg. at 41282. The 2000 regulations remained in place for almost two decades, across multiple changes of administration.

In the course of administering Title X, HHS has developed evidence-based guidance for Title X projects to follow. Most notably, HHS requires providers to adhere to its Quality Family Planning guidelines, which were developed in collaboration with medical experts. SER40-41, 71-72, 82-83, 121. These guidelines instruct that Title X providers should take a "client-centered approach" in which "the client's primary purpose for visiting the service site must be respected." SER71. The guidelines also specify that, during counseling, patients

should be presented with "a discussion of options and appropriate referrals," which "should be made at the request of the client, as needed." SER83; *see* 42 C.F.R. §59.5(a)(5)(ii) (2000). In this respect, the guidelines echo the recommendations of several medical associations—such as the American College of Obstetricians and Gynecologists, the American College of Physicians, and the American Academy of Family Physicians—all of which endorse nondirective options counseling, including referral to appropriate providers. SER267-285, 481-495.

Almost two decades after *Rust*, in 2010, Congress enacted the Patient Protection and Affordable Care Act. Among the Act's provisions is Section 1554, which provides:

> "Notwithstanding any other provision of this Act, the Secretary of [HHS] shall not promulgate any regulation that—(1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care; (2) impedes timely access to health care services; (3) interferes with communications regarding a full range of treatment options between the patient and the provider; (4) restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions; (5) violates the principles of informed consent and the ethical standards of health care professionals; or (6) limits the availability of health care treatment for the full duration of a patient's medical needs."

42 U.S.C. §18114.

B. The Title X Program Today

More than four million Americans rely on affordable family planning services funded by Title X. SER40. California's primary Title X grantee is Essential

Access Health, a nonprofit organization that administers sub-grants to a diverse array of qualified family planning and related preventive health service providers that collectively operate 356 clinic sites in 38 of the State's 58 counties. SER498-499.

Title X programs offer a variety of basic primary and preventive health services, including routine checkups, breast and cervical cancer screenings, birth control, contraception education, and testing and treatment for sexually transmitted infections (STIs), including HIV. SER499-500. Title X-funded programs focus on pre-pregnancy care, such as preventive screenings, tests, and family-planning counseling. *Id.*

HHS and Essential Access Health provide strict oversight of projects that receive Title X grants to ensure that federal funds are not used for any ineligible activities, such as abortion. SER501-502. Existing safeguards to maintain this financial separation include: (1) careful review of grant applications to ensure that the applicant understands and has the capacity to comply with all requirements; (2) independent financial audits to examine whether there is a system to account for program-funded activities and non-allowable program activities; (3) yearly comprehensive reviews of the providers' financial status and budget report; and (4) periodic and comprehensive program reviews and site visits by HHS regional offices. SER 341 n.6, 501-502.

California's existing network of qualified Title X providers has a significant positive impact on health outcomes, delivering a higher quality of services than other publicly funded family planning providers. SER41-46, 141-143. Increased access to contraception, including through Title X, has reduced unintended pregnancy and abortion rates. SER48-49, 138. This access helps to avoid the many risks and adverse outcomes associated with unintended pregnancy for both women and infants, including preterm birth, low birth weight, and stillbirth. SER50-51. Access to contraceptives also helps women time and space their pregnancies, affording women greater control over their life choices, such as pursuing educational and work opportunities. SER49-50.

The State of California, which operates Medi-Cal, the State's Medicaid program, benefits financially from the decreased healthcare costs resulting from Title X's support for effective family planning services. For every dollar invested in publicly funded family planning programs, federal and state governments saved an estimated $7.09 in 2010 in Medicaid-related costs that would otherwise have been associated with unintended pregnancies as well higher rates of adverse birth effects, sexually transmitted diseases, and cervical cancer. SER54-55, 149-150.

C. The 2019 Rule

On March 4, 2019, HHS finalized the rule at issue here, departing markedly from the regulatory regime that has been in place for more than 25 years. 84 Fed.

Reg. 7714. It bans any Title X provider from making any referral of a pregnant patient to a non-Title X provider for an abortion, even in response to the patient's direct request. 42 C.F.R. §§59.5(a)(5); 59.14(a) (2019). It requires providers to refer every pregnant patient for prenatal care, even if the patient has clearly stated her decision to obtain an abortion. *Id.* §59.14(b)(1). In contrast to the 1988 rule, the new rule allows Title X programs to present some information about abortion, but only doctors or other providers with advanced degrees may do so. *Id.* §§59.2; 59.14(b)(1)(i).

The rule significantly restricts the information a Title X provider may give patients regarding abortion and the medical providers who provide them. In response to a patient's direct request for a referral for an abortion, a provider may offer only a "list of licensed, qualified, comprehensive primary health care providers." 42 C.F.R. §59.14(b)(1)(ii). The list "may be limited to those that do not provide abortion," but the provider is not required to inform the patient of that fact. *Id.* §59.14(c)(2). The list may include "some" providers who "provide abortion as part of their comprehensive health care services," but these providers may not account for a "majority" of the providers on the list. *Id.* The list cannot include any women's reproductive health specialists who do not provide "comprehensive health care services." *Id.* Even if a patient specifically asks for information regarding providers who perform abortion, "[n]either the list nor

project staff may identify which providers on the list perform abortion." *Id.* The rule also prohibits providers from doing anything to "promote … or support abortion as a method of family planning," *id.* §§59.5(a)(5); 59.14(a), though it does not provide further guidance on what actions constitute promotion or support for abortion. Separately, the Rule eliminates the previous requirement that all family planning methods and services be "medically approved." 84 Fed. Reg. at 7740-41.

In another departure from longstanding policy, the rule mandates "physical and financial separation" between a Title X program and a facility that engages in "abortion activities." 84 Fed. Reg. at 7715, 7764; *see* 42 C.F.R. §59.15. The rule allows HHS to determine whether a grantee is in compliance with this requirement "based on a review of facts and circumstances." 42 C.F.R. §59.15. "Factors relevant to this determination … include" the existence of separate waiting, consultation, examination, and treatment rooms, office entrances and exits, phone numbers, email addresses, educational services, websites, personnel, electronic or paper-based healthcare records, and workstations. *Id.*

D. Procedural History

On March 4, 2019, California filed a lawsuit in federal district court alleging that the new rule violates the Administrative Procedure Act, 5 U.S.C. §701 *et seq*. ER149-193 (complaint). California alleged that the rule violates the APA both because it is contrary to statute, namely the nondirective-counseling provision and

Section 1554 of the ACA, *see* ER189-190, and because it is arbitrary and capricious, *see* ER191. Essential Access Health and Dr. Melissa Marshall filed a similar lawsuit (which also asserted other constitutional claims), and the two cases were related. California and the other plaintiffs moved for a preliminary injunction on their APA claims.

On April 26, 2019, the district court issued a detailed 78-page order preliminarily enjoining implementation of the rule. The court first concluded that "[t]he record evidence establishes that the irreparable injury, balance of hardships, and public interest factors tip sharply in Plaintiffs' favor." ER22. The court made numerous well-supported factual findings establishing that the rule would "irreparably harm individual patients and public health in California as a whole." ER10. Substantial numbers of existing Title X providers are likely to leave the program rather than comply with the rule's restrictions that compromise the quality of care they provide and violate their ethical obligations. ER23-24. Because of these departures, the court found, Title X patients would have more difficulty obtaining effective methods of birth control, including long-acting reversible contraceptives. ER25-26. Reduced access to effective contraceptive options, in turn, would cause an increase in rates of unintended pregnancy and the adverse health outcomes associated with it, including premature birth, stillbirth, and low birth weight. ER26. In addition, the court found that reduced access to Title X

funded screening would likely prevent diagnosis and early treatment of a variety of illnesses, including breast cancer, cervical cancer, and sexually transmitted infections. ER26. All these public health harms would lead to direct fiscal harm to California in the form of increased Medi-Cal costs. ER26-28.

The district court next determined that the balance of the equities and public interest factors also favored an injunction. ER32-33. The court found that HHS had "identif[ied] no substantiated harm" that would result from a preliminary injunction, in contrast to the "potentially dire public health and fiscal consequences from the implementation of the [rule]." *Id.*

The court also concluded that the plaintiffs were likely to succeed on the merits of their claims that the rule is contrary to the nondirective-counseling provision and Section 1554, and that it is arbitrary and capricious in certain respects. ER33-84.

Based on its analysis of the "statute, regulations, and industry practice," the court concluded that the statutory term "'nondirective counseling' … encompasses referrals." ER36-37. Thus, the rule's "categorical prohibition on providing referrals for abortion … prevents Title X projects from presenting abortion on an equal basis with other pregnancy options," in violation of the nondirective-counseling provision. ER41-42. That prohibition, combined with the rule's "mandate[] that every pregnant patient," even those who have decided to obtain an

abortion, "be referred to 'prenatal health care' … pushes patients to pursue one option over another." ER42. The Court also held, as counsel for HHS acknowledged, that the "referral list restrictions in §59.14(c)(2) stand and fall together with the prohibition on abortion referrals." ER42.

The court next held that the rule likely violated Section 1554 of the ACA. ER43-54. It rejected HHS's argument that the plaintiffs had waived their Section 1554 claim, finding that a variety of comments had alerted the Department to the substance of the claim. ER44-47. On the merits of the claim, the court concluded that the rule would "obstruct patients from receiving information and treatment for their pressing medical needs" and was "squarely at odds with established … standards" of medical ethics. ER51-52.

The district court also determined that the plaintiffs were likely to succeed on the merits of their claim that HHS failed to provide a reasoned explanation for the rule. The court observed that the rule represented a "sharp break from prior policy, without engaging in any reasoned decisionmaking." ER10. The court found that the rule's physical separation requirement was arbitrary and capricious because HHS had relied upon "speculative fears of theoretical abuse of Title X funds," while "turn[ing] a blind eye to voluminous evidence documenting the significant adverse impact the requirement would have on the Title X network and patient health." ER57. The court found other aspects of the rule arbitrary and capricious

as well, including the counseling restrictions, ER70-71; the requirement that only physicians and advanced practice providers may engage in nondirective pregnancy counseling, ER72-73; the removal of the requirement that family planning methods be "medically approved," ER73-74; and HHS's cost-benefit analysis, ER75-82.

Based on its analysis of the preliminary injunction factors, the court concluded that an injunction was warranted to preserve the status quo pending resolution of the litigation. ER10-11.[2] The court limited the reach of the injunction to California, reasoning that "nearly all the harms [the plaintiffs] document are focused on California." ER85-86.

On May 6, 2019, HHS filed a motion asking the district court to stay the preliminary injunction pending appeal. *See* SER5-26. For the first time, HHS identified two specific provisions that, in its view, were severable and should have been excluded from the preliminary injunction order. *See* SER17 (citing 42 C.F.R. §§59.5(a)(13), 59.17). The district court denied the stay motion, though it amended its injunction to exclude sections 59.3 and 59.5(a)(13). ER1-4.

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[2] Three other district courts, confronting similar claims, have likewise determined that the rule violates the APA. *See Oregon v. Azar*, ___ F. Supp. 3d ___, No. 6:19-cv-00317-MC, 2019 WL 1897475, at *7-8 (D. Or. Apr. 29, 2019), *appeal docketed*, No. 19-35386 (9th Cir.); *Washington v. Azar*, 376 F. Supp. 3d 1119, 1130-31 (E.D. Wash. 2019), *appeal docketed*, No. 19-35394 (9th Cir.); *Mayor & City Council of Baltimore v. Azar*, No. 19-cv-01103-RDB, 2019 WL 2298808, at *10 (D. Md. May 30, 2019).

On June 20, 2019, a motions panel of this Court issued a published opinion granting HHS's motion for a stay of the preliminary injunction pending appeal. The panel concluded that HHS "is likely to prevail on its challenge to the district courts' preliminary injunctions." Stay Order at 13. The panel further concluded that the "remaining factors also favor a stay pending appeal." *Id.* at 24. It described the harms the plaintiffs documented and the district court found likely to occur as "comparatively minor," and determined that HHS would be harmed by an injunction because it would be "forced to allow taxpayer dollars to be spent in a manner that it has concluded violates the law." *Id.* California and the other plaintiffs have sought en banc review of the stay order.

SUMMARY OF ARGUMENT

I. The district court did not abuse its discretion in concluding that the plaintiffs are likely to succeed on the merits of their APA claims.

A. Applying well-established principles of statutory construction, the district court correctly determined that the rule likely violates two statutes: the nondirective-counseling provision of the annual Title X appropriations legislation and Section 1554 of the Affordable Care Act, which prohibits HHS from enacting regulations that impede patient access to care or interfere with doctor–patient communications. Each postdates the Supreme Court's decision in *Rust*, which did

not consider the effect of those two statutes on HHS's Title X rulemaking authority.

1. Since 1996, Congress has required that "all pregnancy counseling" funded by Title X "shall be nondirective." Pub. L. No. 115-245, Div. B, Tit. II, 132 Stat. 2981, 3070-71 (2018). The provision prohibits Title X providers who engage in pregnancy counseling from directing or steering patients toward or away from any course of action. Instead, providers must give neutral, factual information responsive to a patient's request. The rule violates that requirement because, by prohibiting referrals for abortion while mandating all patients receive referrals for prenatal care, it ensures that providers will direct patients away from abortion and toward childbirth.

HHS's arguments to the contrary are unpersuasive. It argues that "counseling" does not encompass "referrals" for follow-up care, but statutory text, longstanding regulatory interpretation, and common industry practice show otherwise. HHS also invokes two canons of statutory construction: the presumption against implied repeals and the presumption that Congress does not "hide elephants in mouseholes." Neither applies here. The nondirective-counseling provision does not conflict with, and thus does not impliedly repeal, any aspect of Title X. Rather, as the Court in *Rust* held, Title X "does not speak directly to the issues of counseling [or] referral"; the statute is "ambiguous" on

what type of counseling Title X programs may or must provide. 500 U.S. at 184. The nondirective-counseling provision clarifies that ambiguity, specifying that all counseling must be nondirective—that is, it must present information in a neutral and factual way to allow the patient to make her own decision, rather than attempting to steer the patient toward or away from a particular option. And the annual appropriations legislation funding Title X is hardly a mousehole, but rather a logical place for Congress to place that provision.

In addition, HHS fails to offer any plausible alternative interpretation of the nondirective-counseling provision. It suggests an atextual, one-sided definition of "nondirective," prohibiting providers from steering patients *toward* abortion, but allowing them to steer patients *away from* abortion. The legislative history does not support that interpretation, and at any rate this Court must follow the text of the statute, not HHS's unsupported speculation about what some members of Congress may have wanted.

2. The rule also violates Section 1554 of the Affordable Care Act, which prohibits HHS from promulgating any regulation that (among other things) "creates unreasonable barriers" or "impedes timely access" to health care, "restricts" or "interferes with communications" between a patient and provider "regarding a full range of treatment options," or "violates the principles of informed consent and the ethical standards of health care professionals." 42

U.S.C. §18114. The rule does all of these things. It places obstacles in the way of Title X patients who seek to obtain abortions, delaying and affirmatively interfering with their access to time-sensitive medical care. It restricts provider–patient communications, prohibiting referrals for one treatment option and mandating referrals for another, without regard to the patient's wishes. And as numerous organizations of medical professionals have warned, the rule would require providers to violate their ethical obligations to patients by withholding relevant information and not abiding by patient decisions.

B. The rule violates the APA's prohibition on arbitrary and capricious agency decisionmaking. The rule seeks to require costly physical separation of facilities serving Title X patients from facilities providing abortions, ostensibly because of concern about misuse of Title X funds. But HHS cannot cite a single instance from the past three decades—during which shared facilities have been permitted, under certain conditions—in which a Title X provider has misused funds to support abortion.

As the administrative record shows, the rule's referral restrictions will cause many providers to leave the program rather than compromise the quality of care they offer or otherwise violate ethical standards. That exodus of providers will reduce the ability of Title X patients to access care, yet HHS promulgated the rule with no serious plan to preserve access and no evidence that alternative similarly

qualified providers can or will fill the gap. And HHS has offered no reasoned justification for its requirement that only providers with advanced degrees engage in pregnancy counseling, or for its elimination of a requirement that Title X family planning methods be "medically approved."

II. The district court did not abuse its discretion in determining that California would suffer irreparable harm to its public health and finances if the rule were to go into effect. That conclusion is rooted in numerous well-supported factual findings regarding the likely effect of the rule. Providers would withdraw from the program, reducing access to care. Rates of unintended pregnancy and complications at birth would increase; early diagnoses of serious but preventable illnesses would decrease. Patients seeking information about where to exercise their constitutional right to obtain an abortion would be kept in the dark. No similar harm would flow from keeping the decades-old Title X regulatory status quo in place pending resolution of judicial challenges to the rule. The district court also tailored the scope of the injunction appropriately.

III. The motions panel's published stay order does not control the Court's disposition of this case. The question before the motions panel was whether HHS would likely succeed in convincing *this* panel to reverse the district court's injunction. The motions panel's resolution of that preliminary, predictive

question—based on abbreviated briefing and without oral argument—does not bind this panel in addressing the merits of HHS's appeal.

STANDARD OF REVIEW

This Court reviews a "district court's decision to grant or deny a preliminary injunction for abuse of discretion." *Hernandez v. Sessions*, 872 F.3d 976, 987 (9th Cir. 2017). This "review is limited and deferential." *Id.* The Court "review[s] the district court's legal conclusions *de novo*" and "the factual findings underlying its decision for clear error." *Id.* The Court reviews "the injunction's scope for abuse of discretion." *K.W. ex rel. D.W. v. Armstrong*, 789 F.3d 962, 969 (9th Cir. 2015).

To obtain a preliminary injunction, a party "must meet one of two variants of the same standard." *Alliance for the Wild Rockies v. Pena*, 865 F.3d 1211, 1217 (9th Cir. 2017). First, the party may "show 'that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest.'" *Id.* (quoting *Winter v. NRDC*, 555 U.S. 7, 20 (2008)). Alternatively, "[u]nder the 'sliding scale' variant of the *Winter* standard," if a party shows that the "balance of hardships tips *sharply* in [its] favor," the party need only establish "serious questions going to the merits," which is "a lesser showing than likelihood of success on the merits." *Id.*

ARGUMENT

I. THE DISTRICT COURT DID NOT ABUSE ITS DISCRETION IN DETERMINING THAT THE PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS OF THEIR ADMINISTRATIVE PROCEDURE ACT CLAIM

A. The Rule Is Contrary to Law

California is likely to succeed on the merits of its claims that the rule is "not in accordance with law." 5 U.S.C. §706(2)(A). It violates two statutes enacted by Congress: the nondirective-counseling provision and Section 1554 of the ACA.

At the outset, HHS contends (and the motions panel suggested) that the district court's decision should be reversed because the Supreme Court in *Rust* upheld similar regulations, affording *Chevron* deference to HHS's interpretation of Section 1008, which the Court deemed ambiguous. AOB15-21; *see* Stay Order at 14. But the question is not whether HHS's current interpretation of Section 1008 is permissible in a vacuum; the question is whether it is permissible in light of two other statutes enacted since *Rust*, the nondirective-counseling provision and Section 1554 of the ACA. *See Vance v. Hegstrom*, 793 F.2d 1018, 1024 (9th Cir. 1986) (in issuing regulations, "the Secretary may not read [one] subsection … independently of" others). *Rust* thus cannot answer the question of whether the rule violates these two statutes. *See* ER34. California addresses below HHS's related arguments that in light of *Rust*, the presumption against implied repeal of statutes and the presumption against "hid[ing] elephants in mouseholes," *Whitman*

v. Am. Trucking Ass'ns, 531 U.S. 457, 468 (2001), support its position. *See* AOB23, 30, 36; *infra* at 35-36, 44.

1. The Rule Violates the Nondirective-Counseling Provision

1. Every year since 1996, in its appropriations legislation funding Title X, Congress has included a provision requiring that "all pregnancy counseling shall be nondirective." ER34-35; *see, e.g.*, Pub. L. No. 115-245, Div. B, Tit. II, 132 Stat. 2981, 3070-71 (2018); Pub. L. No. 104-134, 110 Stat. 1321, 1321-22 (1996).

The district court correctly determined that the rule's restrictions on referrals violate this statutory command. *See* ER41-42. As HHS has long recognized, in nondirective counseling, "grantees … may not steer or direct clients toward selecting *any option*, including abortion, in providing options counseling." 65 Fed. Reg. at 41273 (emphasis added). As used in this context, the phrase "nondirective counseling" appears to have originated in HHS legal memoranda from the 1970s, which drew a "distinction between directive ('encouraging or promoting' abortion) and nondirective ('neutral') counseling on abortion, prohibiting the former and permitting the latter." *Nat'l Family Planning*, 979 F.2d at 229. The rule itself reflects a similar understanding of the term, explaining that the purpose of nondirective counseling is "to assist the patient in making a free and informed decision." 84 Fed. Reg. at 7747. It entails "the meaningful presentation of options where the [provider] is not suggesting or advising one option over another" but

rather "present[s] the options in a factual, objective, and unbiased manner." *Id.* at 7716, 7747.

The rule does not comply with that text or spirit of that requirement. It prohibits Title X providers from giving any referrals for abortion or information about providers who perform abortions, even for women who affirmatively request it. At the same time, the rule mandates that Title X providers refer all women—even those who have decided to terminate their pregnancies—to prenatal care. The rule thus requires Title X providers to direct their patients away from abortion and toward childbirth. Counseling of that sort is not "nondirective." Indeed, HHS agrees that if "abortion [were] the only option presented" by a provider, that "would violate … the Congressional directive that all pregnancy counseling be nondirective." 84 Fed. Reg. at 7747. The same is true of the rule's mandate that providers refer all patients for prenatal care and not refer any patients for abortion.

In its stay order (at 18), the motions panel concluded that this panel would likely hold that "referrals do not constitute 'pregnancy counseling.'" This Court is not bound by that prediction, *see infra* at 60-62, and should not follow it. As the district court explained, "statute, regulations, and industry practice" all confirm that referrals are included within the Act's mandate of nondirective counseling. ER37; *see* ER36-41.

A neighboring provision of the Public Health Service Act, 42 U.S.C. §254c-6(a)(1)—which appears to be the "only [other] instance[] in which Congress has used the term 'nondirective counseling,'" ER37—demonstrates that counseling does include referrals. In Section 254c-6(a)(1), Congress mandated that HHS make grants to train staff "in providing adoption information *and referrals* to pregnant women on an equal basis with all *other courses of action included in nondirective counseling* to pregnant women" (emphases added). As that formulation indicates, Congress considered "referrals" for other services to be among the "courses of action included in nondirective counseling." Because "a legislative body generally uses a particular word with a consistent meaning in a given context," *Erlenbaugh v. United States*, 409 U.S. 239, 243 (1972), "nondirective counseling" should have a consistent meaning in the two statutes, encompassing referrals. Congress has made clear in several other statutes as well that medical and other professional counseling includes referrals.[3]

The rule also itself repeatedly characterizes referrals as part of counseling. *See* ER37-38. It acknowledges that Section 254c-6(a)(1) reflects Congress's

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

"intent that postconception adoption information and referrals be included as part of any nondirective counseling in Title X projects." 84 Fed. Reg. at 7733; *see also id.* at 7730 (same). The rule thus provides that "nondirective pregnancy counseling can include … referrals to adoption agencies." *Id.* at 7730; *see also id.* at 7733-34 ("Title X providers may provide adoption … referral … as part of nondirective postconception counseling."). There is no reason to believe—and HHS does not contend—that somehow referrals for adoption are part of "nondirective counseling" but referrals for abortion are not. Moreover, as early as 1981, HHS defined counseling in its Title X Guidelines to include referrals. *See* U.S. Dep't of Health & Human Servs., *Program Guidelines for Project Grants for Family Planning Servs.* §8.2 (1981) ("Post-examination counseling should be provided to assure that the client … receives appropriate referral for additional services as needed.").

As the district court recognized, "accepted usage within the medical field" also supports the conclusion that "nondirective counseling" includes referrals. ER38; *see La. Pub. Serv. Comm'n v. FCC*, 476 U.S. 355, 372 (1986) ("technical terms of art should be interpreted by reference to the trade or industry to which they apply"). The "Pregnancy Testing and Counseling" section of HHS's own guidelines advises providers that, during counseling, "[pregnancy] test results should be presented to the client, followed by a discussion of options *and*

appropriate referrals." SER82-83 (emphasis added). In addition, the guidelines advise that counseling "should be provided in accordance with recommendations from professional medical associations, such as ACOG [the American College of Obstetricians and Gynecologists] and AAP [the American Academy of Pediatrics]." SER83. Each of these organizations explicitly recommends that referrals be provided as part of counseling. SER135. The American Medical Association, likewise, advises that a doctor's failure "to provide any and all appropriate referrals" as part of counseling a patient would be "contrary to the AMA's Code of Medical Ethics." SER315. That accords with common sense: A patient who visits a general practitioner and receives a diagnosis would naturally expect to receive a referral for follow-up care.

2. HHS offers a variety of arguments why the rule comports with the nondirective-counseling provision, but none is persuasive.

First, HHS argues—and the motions panel agreed—that the "presumption against implied repeals" precludes interpreting the nondirective-counseling provision to have "silently eliminate[d] Title X's authorization for [the rule's] funding conditions." AOB23; Stay Order at 16-18. But the presumption against implied repeals has no role to play here. It disfavors an interpretation of a statute that would create an "irreconcilable conflict" with, and thus impliedly repeal, an earlier-enacted statute. *Carcieri v. Salazar*, 555 U.S. 379, 395 (2009). All parties

agree that here there is no such conflict between the nondirective-counseling provision and Section 1008. *See* AOB23; Stay Order at 17.

The question, then, is how best to construe the two provisions in a manner that "harmonize[s]" them, giving effect to each. *Nat'l Ass'n of Home Builders v. Defenders of Wildlife*, 551 U.S. 644, 666 (2007). Neither HHS nor the motions panel has identified a plausible construction of the nondirective-counseling provision that would harmonize it with their interpretation of Section 1008. *See infra* at 32-33. The plaintiffs and the district court, by contrast, have offered an interpretation that harmonizes the two statutes: While Section 1008 prohibits Title X funds from being used to pay for abortions, the nondirective-counseling provision requires providers who engage in counseling to provide neutral, factual information regarding any option in which a patient expresses interest, including abortion.

The nondirective-counseling provision clarified an ambiguity that the *Rust* Court identified in Section 1008. *Rust* held that the then-Secretary's interpretation of Section 1008—as prohibiting all counseling regarding abortion—was a "permissible construction of the statute," not that it was the only reasonable interpretation. 500 U.S. at 184 (noting that Section 1008 "does not speak directly to the issues of counseling, referral, advocacy, or program integrity"). That was true in 1991, because Congress had not yet enacted the nondirective-counseling

provision. Now it has, and the provision makes clear that counselors in Title X programs may not direct pregnant patients toward or away from any option, but instead must provide neutral, factual information in response to patient requests. That is not a "repeal" of Section 1008; its prohibition on using Title X dollars to perform abortions remains in place. Rather, HHS no longer has the authority to interpret Section 1008 to prohibit Title X providers from counseling patients regarding abortion when they request it.

That situation—in which a later-enacted statute "give[s] meaning to a previously enacted ambiguity"—does not implicate the canon against implied repeals. *J.E.M. Ag Supply, Inc. v. Pioneer Hi-Bred Int'l, Inc.*, 534 U.S. 124, 146 (2001) (Scalia, J., concurring); *see also Am. Bank & Trust Co. v. Dallas County*, 463 U.S. 855, 872 (1983) (presumption against implied repeals "does not justify the use of an unnecessary construction of the language of an ambiguous [earlier-enacted] statute"). "At the time a statute is enacted, it may have a range of plausible meanings," but "subsequent acts can shape or focus those meanings" without impliedly repealing the earlier statute. *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 143 (2000); *see also United States v. Fausto*, 484 U.S. 439, 453 (1988) ("the implications of a statute may be altered by the implications of a later statute" without violating the presumption against implied repeals).

There are several other textual indications that the presumption against implied repeal does not apply. Contrary to HHS's view (AOB23), the nondirective-counseling provision is not "silent[]" on the question of what type of counseling may occur in Title X programs—it expressly mandates that any counseling be "nondirective." The presumption against implied repeal does not apply when, as here, the later-enacted statute "*expressly*" addresses the question at issue and "the only question is its scope." *Republic of Iraq v. Beaty*, 556 U.S. 848, 861 (2009). The presumption also generally applies only when the earlier-enacted statute addresses "a narrow, precise, and specific subject," and the "later enacted statute cover[s] a more generalized spectrum." *Radzanower v. Touche Ross & Co.*, 426 U.S. 148, 153 (1976). Here, the later-enacted statute (the nondirective-counseling provision) is more specific: It expressly mandates that Title X programs provide a particular type of counseling, whereas Section 1008 "does not speak directly" to that issue. *Rust*, 500 U.S. at 184.

Home Builders, the principal case upon which HHS relies (AOB23, 31), is inapposite. The Court there applied the presumption because the respondent's interpretation of the later-enacted statute would have resulted in the "implicit repeal" of a "statutory mandate" and several other "categorical statutory commands" in the earlier-enacted statute. 551 U.S. at 664; *see id.* at 663-64. Here, as discussed, Section 1008 contains no mandate or command repealed by the

nondirective-counseling provision; it simply does not address the type of counseling Title X programs may provide.

Second, HHS contends that the rule's prohibition on abortion referrals does not violate the nondirective-counseling provision because "a doctor's *failure* to refer a patient for an abortion does not *direct* the patient to do anything." AOB24. But a doctor does not "direct" a patient to do anything in the sense of "order[ing]" or "command[ing]" them. Webster's New World Dictionary, Third College Edition 389 (1991). Rather, as the rule acknowledges, and consistent with standard professional understanding of this terminology, Congress used "direct" in the sense of "guide" or "turn or point (a person or thing) toward an object or goal." *Id.*; *see* 84 Fed. Reg. at 7716 (nondirective counseling means "not suggesting or advising one option over another"). The type of counseling laid out in the rule is not "nondirective" in that sense because it steers patients away from abortion and toward childbirth. *See supra* at 24-25.

Third, alternatively, HHS argues that Congress intended an atextual and one-sided definition of "nondirective" in which it means only that providers may not "steer clients *to* abortion," but may steer clients *away from* abortion. AOB24 (emphasis added); *see also* AOB30. HHS cites a statement by Representative Greenwood, a sponsor of the legislation that first enacted the nondirective-counseling provision, noting that providers may not "suggest that a client choose

abortion." AOB31 (quoting 141 Cong. Rec. H8250 (Aug. 2, 1995)). But it is undisputed that counselors may not steer patients toward abortion. Representative Greenwood did not say that the legislation allows counselors to direct clients *away from* abortion, which would be at odds with the plain meaning of "nondirective."

Moreover, as the Supreme Court has cautioned, "floor statements by individual legislators rank among the least illuminating forms of legislative history." *NLRB v. SW General, Inc.*, 137 S. Ct. 929, 943 (2017). Even if the floor statement by Representative Greenwood supported the HHS's interpretation (which it does not), this Court could not assume that one legislator's statement reflected the intent of Congress as a whole. Congress mandated that all counseling be "nondirective," not "nondirective in the direction of abortion." This Court should rely upon the statutory text.

Fourth, HHS contends, and the motions panel agreed, that the rule does not violate the nondirective-counseling provision because counseling does not encompass referrals. AOB25-28; Stay Order at 18. This argument overlooks the key textual indication that Congress understands referrals to be included within nondirective counseling. A neighboring provision specifies that "adoption information *and referrals*" should be provided "on an equal basis with *all other courses of action included in nondirective counseling*." 42 U.S.C. §254c-6(a)(1) (emphases added); *see supra* at 26. HHS argues that the term "included in

nondirective counseling" modifies the term "courses of action," not "referrals." AOB27. That argument "totally ignores the word 'other'," *Garcia v. United States*, 469 U.S. 70, 74 (1984), which makes clear that referrals are also "included in nondirective counseling." *See id.* at 73-74 (concluding that in the statutory phrase "money or other property of the United States," the word "money" is also modified by "of the United States").

HHS also notes that counseling and referral are sometimes referred to separately in certain statutory and regulatory contexts. AOB25-27. But as discussed above, in contexts more closely related to the rule, Congress and HHS have indicated that referral *is* included within nondirective counseling. *See supra* at 26. And the fact that Congress and the Department sometimes refer to counseling and referral separately is not an indication that counseling does not encompass referrals. As the Supreme Court recently observed, Congress sometimes "list[s]" items separately even though they "have substantial overlap." *Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1814 n.1 (2019) (reasoning that "many manual instructions surely qualify as guidelines of general applicability" even though the statute listed "manual instructions" and "guidelines of general applicability" separately). That insight aligns with common usage. For example, one might refer to "roads and bridges," but that does not mean that a road ceases to be a road when it crosses a bridge.

Fifth, HHS argues that the district court's interpretation of the nondirective-counseling provision suggests that "the 1996 Congress resurrected" earlier legislation vetoed in 1992, which HHS considers unrealistic. AOB29. But "unsuccessful attempts at legislation are not the best of guides to legislative intent," and it is especially "hazardous" to attempt to infer the intent of one Congress from failed legislation in another. *City of Milwaukee v. Illinois*, 451 U.S. 304, 332 n.24 (1981). That is doubly true here, where HHS proposes to infer the intent of a later Congress from legislation that an earlier Congress passed but a prior President vetoed. Moreover, the nondirective-counseling provision is not simply a reincarnation of the vetoed 1992 legislation, which included a variety of provisions not mirrored in the later appropriations legislation.

Sixth, HHS cites the aphorism that Congress does not "hide elephants in mouseholes," AOB 30—that is, it normally "does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions." *Whitman*, 531 U.S. at 468. But the nondirective-counseling requirement is hardly vague or an ancillary provision: It is found in the legislation that funds Title X grants, and speaks directly to the question of what type of counseling providers must offer. Indeed, the same legislative history HHS cites underscores that Congress intended the appropriations legislation in question to impose substantive requirements on

the type of counseling that may occur through Title X. *See* 141 Cong. Rec. H8250 (Rep. Greenwood).

3. Apart from the rule's referral restrictions, the district court also correctly concluded that its counseling restrictions violate the nondirective-counseling provision. ER42-43. These restrictions bar providers from doing anything to "encourage," "promote," "support," or "advocate" abortion. *See id.*

As the district court concluded, the "murkiness" of these regulatory provisions "is likely to chill discussions of abortion and thus inhibits neutral and unbiased counseling." ER43. To the extent these provisions simply restate the statutory command that all counseling be "nondirective"—*i.e.*, that it be objective and factual, and not designed to steer the patient toward any course of action—the provisions are, of course, in compliance with law. But HHS has not conceded that these vague regulations are simply coextensive with the nondirective-counseling provision itself.[4] Nor has HHS offered any other clear, noncircular definition of what the provisions mean, forcing "providers desiring to explain the abortion option" to "walk on eggshells" to avoid a potential transgression. ER43. That

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[4] This Court could interpret these provisions to do nothing more than require providers to comply with the nondirective-counseling mandate. *See Decker v. Nw. Envtl. Def. Ctr.*, 568 U.S. 597, 609 (2013) (court may "adopt a purposeful but permissible reading of the regulation to bring it into harmony with the statute" (internal quotation marks and alterations omitted)).

would preclude neutral, unbiased counseling regarding abortion, contrary to Congress's intent.

2. The Rule Violates Section 1554 of the Affordable Care Act

Separately, the district court correctly held that the rule likely violates Section 1554 of the ACA, 42 U.S.C. §18114. ER51-54.

1. Section 1554 is located in a subchapter of the ACA that adopts a variety of general protections for healthcare consumers. *See* 42 U.S.C. §§18111-18122. Like the nondirective-counseling provision, Section 1554 seeks to protect the ability of patients to make their own healthcare decisions. It provides that, "[n]otwithstanding any other provision of this Act, the Secretary of Health and Human Services shall not promulgate any regulation that—

> (1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care;
>
> (2) impedes timely access to health care services;
>
> (3) interferes with communications regarding a full range of treatment options between the patient and the provider;
>
> (4) restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions; [or]
>
> (5) violates the principles of informed consent and the ethical standards of health care professionals[.]"

42 U.S.C. §18114.

The rule's restrictions on abortion referrals violate several of these provisions. By flatly prohibiting a Title X-funded provider from informing a patient about facilities that provide abortions, the rule "interferes with" communications about one particular "treatment option[]." 42 U.S.C. §18114(3). Similarly, it "restricts" providers from making a "full disclosure of all relevant information to patients making health care decisions." *Id.* §18114(4). There can be no question that a referral for an abortion provider is "relevant information" to a pregnant woman who seeks to terminate her pregnancy.

The rule also creates an "unreasonable barrier[] to the ability" of Title X patients to obtain abortions, 42 U.S.C. §18114(1), and "impedes timely access" to abortion for Title X patients, *id.* §18114(2). That is especially so because not only does the rule prohibit abortion referrals, it also includes several related provisions that appear specifically designed to keep patients in the dark regarding where they may be able to obtain an abortion, even if they have already elected to pursue that option. *See supra* at 11-12; ER18-19. For instance, even if a client specifically requests a referral to an abortion provider, a Title X provider may (at most) offer a list of "comprehensive primary health care providers … some, but not the majority of which, also provide abortion," yet "[n]either the list nor project staff may identify which providers on the list perform abortion." 42 C.F.R. §59.14(c)(2). Providers who specialize in reproductive care but do not provide comprehensive

care may not be included, even if they are the highest quality, most convenient, or most affordable providers. *Id.* And the list "may be limited to those that do not provide abortion." *Id.* That approach forces patients to investigate on their own which of the listed providers (if any) perform abortions, creating an "unreasonable barrier" and "imped[ing] timely access" to abortion.

The rule's prohibition on abortion referrals is also, as the district court concluded, "squarely at odds with established ethical standards and therefore Section 1554(5)." ER52; *see* ER52-54. HHS's own guidelines recognize that "[r]eferral" for "follow-up care should be made at the request of the client, as needed." SER83. The rule prohibits providers from complying with that guidance: It prohibits abortion referrals for patients who want one, and mandates referrals to prenatal care for patients who do not want such care. Numerous associations of medical professionals agree with the district court's conclusion. *See* ER52-53. For instance, the American Medical Association has advised that the referral restrictions "are contrary to the AMA's Code of Medical Ethics," SER315, and the American Public Health Association has advised that the restrictions "violate[] core ethical standards," SER320.

2. None of the contrary arguments advanced by HHS is persuasive.

First, HHS argues that "plaintiffs have waived any challenge to the Rule under §1554" by failing to object on this ground at the administrative level.

AOB32-33. But HHS does not dispute that many commenters brought the substance of these issues to its attention. That is sufficient. "Plaintiffs need not state their claims in precise legal terms, and need only raise an issue 'with sufficient clarity to allow the decision maker to understand and rule on the issues raised.'" *Nat'l Parks & Conserv. Ass'n v. Bureau of Land Mgmt.*, 606 F.3d 1058, 1065 (9th Cir. 2010); *see also, e.g.*, *Idaho Sporting Congress, Inc. v. Rittenhouse*, 305 F.3d 957, 966 (9th Cir. 2002) (plaintiffs need not "incant … magic words" or cite specific legal authority).[5]

As the district court observed, although no commenters referenced Section 1554 specifically, "numerous comments use[d] identical or substantially identical language to Section 1554 to describe how the Final Rule would impede access to care." ER45. Commenters objected to the rule on the ground that it would "ban Title X providers from giving women full information about their health care options" (SER32); would "prevent Title X providers from sharing complete and accurate medical information necessary to ensure that their patients are able to … obtain timely care" (SER31); and would "limit[] how Title X providers can discuss and/or counsel on the full range of sexual and reproductive health care options with

[5] The motions panel stated that it "seems likely" that a challenge to the rule under Section 1554 had been waived, but the panel ignored these Ninth Circuit cases, and relied instead on a D.C. Circuit case that is not on point. *See* Stay Order at 19-20.

their patients" (SER32). Commenters also noted that the rule would "require[] physicians to disregard their Code of Medical Ethics" and would violate "ethical and professional standards around informed consent." SER33-34.

Second, HHS asserts that the rule does not violate Section 1554 because "it simply limits what the government chooses to *fund* through the Title X grant program." AOB33. But the plain text of Section 1554 states categorically that the Secretary "shall not promulgate any regulation" that has the described effects; it does not say that the Secretary shall not promulgate such a regulation except in the course of establishing grant criteria. The rule undoubtedly is a "regulation," and for the reasons just described (*supra* at 38-39), for Title X patients, it has the types of effects that Section 1554 prohibits.

Third, HHS contends that the Supreme Court's holding in *Rust* that the 1988 regulation did not violate the First Amendment or due process clause, 500 U.S. at 200-203, defeats the plaintiffs' Section 1554 claim because it is "substantively the same as" those constitutional claims. AOB34. That argument is mistaken because, as the district court observed, "[t]he statutory mandates of Section 1554 are far more specific than the constitutional requirement asserted in *Rust*." ER50.

The Court held in *Rust* that the challenged regulation did not unlawfully burden a patient's right to obtain an abortion because the patient was "in no different position than she would have been if the Government had not enacted

Title X." 500 U.S. at 202. In enacting Section 1554, however, Congress made the policy choice to constrain HHS's regulatory authority *even though* patients may have no underlying constitutional right to government-funded medical care. Patients may have no constitutional right to (for instance) "timely access to health care services" or information "regarding a full range of treatment options," 42 U.S.C. §18114(2)-(3), yet Section 1554 nonetheless prohibits HHS from promulgating any regulation that impedes or interferes with that access and information.

Moreover, as the district court noted, the rule "go[es] far beyond anything in the 1988 regulations," and "[u]nlike in *Rust*," its referral restrictions threaten to "misdirect … unsuspecting patients" who seek information regarding abortion, making them "*worse* off" than if they had never visited a Title X provider. ER 50-51.

Fourth, HHS argues that the rule does not require providers to violate standards of medical ethics because "not referring for or promoting abortion is consistent with medical ethics, as evidenced by the many federal conscience statutes giving medical providers that option." AOB35. Even if that were correct, it would not save the rule from violating Section 1554, because it would still interfere with communications between the patient and provider and restrict access to care. *See supra* at 38-39; 42 U.S.C. §18114(1)-(4). At any rate, the premise of

the argument is flawed: Even if medical providers with certain religious beliefs may in certain circumstances obtain an exemption from an otherwise applicable ethical standard, that does not mean other providers need not follow it. Moreover, it is not at all clear that ethical standards allow a provider, based on religious beliefs, to refuse to provide information relevant to a patient's request without making "other arrangements" to ensure that the patient receives the requested information. 65 Fed. Reg. at 41273-74 (citing 42 U.S.C. §300a-7(d)).

Fifth, echoing its argument regarding the nondirective-counseling provision, HHS contends that canons of statutory construction counsel against the district court's interpretation of Section 1554. AOB36-37. Here too, HHS's position lacks merit.

Citing the canon that "the specific governs the general," HHS asserts that "Title X's specific delegation of authority to the Secretary to adopt the Rule" should prevail over "the general directives in §1554." AOB36. But Title X contains no "specific delegation" of authority to enact the challenged provisions of the rule. The statute "does not speak directly to the issues of counseling, referral, advocacy, or program integrity"; it is "ambiguous" on these topics. *Rust*, 500 U.S. at 184; *supra* at 29-30. Section 1554 is the more specific statute in this context, because it expressly places conditions on HHS's regulatory authority.

HHS argues that "it is implausible that Congress tucked away an implied repeal of Title X's authorization for the Rule … in the mousehole of §1554." AOB36. Just as these canons had no role to play in interpreting the nondirective-counseling provision, *supra* at 28-32, 35-36, they are inapplicable here as well. Section 1554 did not effectuate an "implied repeal"; it simply cabined in certain respects HHS's regulatory discretion, clarifying an issue on which Title X is silent. *See* ER49. And Section 1554 is not a mousehole; it is an opening of commensurate size with the statutory question of HHS's authority to impose the challenged provisions of the rule. Congress enacted it alongside other significant new consumer protections, such as Section 1557's nondiscrimination provision. *See* 42 U.S.C. §18116. As one commentator noted shortly after it was enacted, Section 1554 is "[a]n important provision for consumers" because it "prohibits the Secretary of HHS from promulgating regulations that adversely affect access" to care. E. Kinney, *Administrative Law Protections in Coverage Expansions for Consumers Under Health Reform*, 7 J. Health & Biomedical L. 33, 46 (2011). That is the essence of California's argument here.

Finally, HHS argues that because Section 1554 states that its provisions apply "[n]otwithstanding any other provision of this Act," it does not "implicitly repeal *other, pre-existing statutes* such as §1008." AOB36-37. The "notwithstanding" clause means that Section 1554 "override[s] conflicting provisions" of law only

within the ACA. *Cisneros v. Alpine Ridge Group*, 508 U.S. 10, 18 (1993). As discussed, however, here there is no conflict with any provision of Title X, so the "notwithstanding" clause has no role to play and the categorical restrictions on HHS's regulatory authority contained in Section 1554 apply directly. HHS interprets Section 1554 as though it cabined its authority in rulemaking only "under this Act" or "in enforcing this Act." But that is not what the text says. When Congress means to restrict rulemaking authority only under a particular statute or section, it knows how to do so. *See, e.g.*, 42 U.S.C. § 13257(b)(2) ("The Secretary shall not promulgate a rule under this subsection" absent certain conditions); 25 U.S.C. § 3307(d) (restricting the effect of "[r]egulations issued pursuant to this subchapter"). Congress here enacted a broader provision to protect patients from precisely the kind of harm the rule will cause.

B. HHS Failed to Provide a Reasoned Justification for the Rule

The district court identified several respects in which the rule is likely arbitrary and capricious in violation of the APA. *See* 5 U.S.C. §706(2)(A); *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). That conclusion does not reflect any abuse of discretion, and the factual findings underlying it are amply supported, not clearly erroneous.

On appeal, HHS does not dispute the district court's conclusion that it was required to provide a "'more detailed justification than what would suffice'" for a

newly adopted policy, due in part to the "'serious reliance interests'" the well-established prior Title X policy had engendered. ER55 (quoting *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009)); *see also* ER62; *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126 (2016) (requiring additional justification in light of "decades of industry reliance on the Department's prior policy"). HHS's rationales for the rule do not meet that standard.

1. The Physical Separation Requirement

The district court correctly determined that HHS failed to provide an adequate justification for the rule's requirement that Title X providers be physically separate from facilities that provide or make referrals for abortion. ER57-70. The Department asserted that the requirement is necessary to avoid the "risk" of improper commingling of funds or use of Title X funds for impermissible purposes, but the district court found no "evidence in the record of *actual* co-mingling or misuse of Title X funds." ER58; *see* 84 Fed. Reg. at 7773. Nor does HHS cite any such evidence on appeal.

It is true, as the district court recognized, that agencies generally may "adopt prophylactic rules to prevent potential problems before they arise," and that agencies' "predictive judgments … are entitled to deference." ER60. But those predictive judgments must "be based on some logic and evidence, not sheer speculation." *Sorenson Commc'ns Inc. v. FCC*, 755 F.3d 702, 708-09 (D.C. Cir.

2014) (finding arbitrary and capricious an FCC regulation designed to deter fraud where there was "no evidence of fraud"); *see also Nat'l Fuel Gas Supply Corp. v. FERC*, 468 F.3d 831, 841 (D.C. Cir. 2006) (Kavanaugh, J.) (vacating FERC order where agency had "provided no evidence of a real problem").

Indeed, the very case law HHS cites (AOB41) underscores the flaws in its rationale for the physical separation requirement. In *Trout Unlimited v. Lohn*, 559 F.3d 946 (9th Cir. 2009), this Court deferred to the agency's predictive judgment that was based on "substantial … scientific data," where the agency sought to "decide between conflicting scientific evidence." *Id.* at 959; *see also BNSF Ry. Co. v. Surface Transp. Bd.*, 526 F.3d 770, 781 (D.C. Cir. 2008) ("declin[ing] to enter" a "hyper-technical fray" between agency and party regarding model predicting likely future productivity of hypothetical future railroad). Here, in contrast, HHS's assertion that the physical separation requirement is necessary to avoid improper use of funds is based on no real-world evidence at all, despite nearly three decades of experience under the prior policy.

HHS's speculation is especially inadequate in light of the detailed justification it provided in 2000 for treating "financial separation" as "sufficient" to achieve compliance with Section 1008. ER62. In 2000 it noted that "'Title X grantees are subject to rigorous financial audits'" allowing it to detect any improper expenditure of funds. *Id.* (quoting 65 Fed. Reg. at 41275). HHS offers

no explanation for its departure from that prior position, which has been borne out by experience. Again, the case law HHS cites only confirms the inadequacy here. In *International Rehabilitative Sciences, Inc. v. Sebelius*, 688 F.3d 994 (9th Cir. 2012) (cited at AOB39), this Court held that the agency had sufficiently justified its change in position when it explained that studies underlying its prior position came from biased sources and suffered from methodological deficiencies. *Id.* at 1001. That sort of reasoned analysis is lacking in this case.

HHS notes that *Rust* rejected an arbitrary-and-capricious challenge to the 1988 regulations. AOB38. But as the district court reasoned, "[t]he justifications supporting the 1988 regulations … cannot insulate the Final Rule from review now, almost three decades later." ER56. The rule must be evaluated in light of the current administrative record, the many years of experience under the prior policy, and "the grounds that the agency invoked when it took the action" challenged here, *i.e.*, in the 2019 rulemaking. *Michigan v. EPA*, 135 S. Ct. 2699, 2710 (2015).

Separately, HHS overlooked the significant financial costs the physical separation requirement imposes on providers, which will hinder their ability to serve patients. To comply with the rule, providers will need to maintain separate "'treatment, consultation, examination and waiting rooms, office entrances and exits, … phone numbers, email addresses, educational services, and websites'" for their Title X programs and their non-Title-X programs. ER66 (quoting 42 C.F.R.

§59.15(a)-(c)). Providers constructed physical space in reliance on the prior rule's assurance that physical separation was not required. Yet HHS summarily dismissed comments from providers estimating that, for example, the capital costs of renovation and construction alone to achieve compliance would be "nearly $625,000 per affected service site," in addition to a substantial increase in ongoing operating costs. ER66-67; *see* SER362-363, 396-397. In light of those reliance interests, the APA demands more. *See Encino Motorcars*, 136 S. Ct. at 2126.

HHS does not dispute that evidence. Instead, it asserts that it "concluded that the Rule was necessary to comply with Title X notwithstanding those predicted costs." AOB41. Even if Congress had not imposed new restrictions since *Rust*, *Rust* expressly held that Section 1008 "does not speak directly" to "program integrity," so the physical separation requirement is not *required* for compliance. 500 U.S. at 184. HHS cites no authority for the proposition that it may adopt a policy with substantial costs and no apparent benefit where the underlying statute is ambiguous and does not mandate that approach. A "reasoned analysis" is still required. *Id.* at 187.

HHS also does not dispute the district court's finding that as a result of the high costs of complying with the physical separation requirement, "large numbers of Title X providers would be forced to leave the program." ER67; *see* SER202-203, 278-279, 296-297, 359-360, 397-399. The likely departure of these providers

would significantly reduce both the quantity and quality of Title X services. ER67-68; *see* SER153-154, 380-382, 398, 508-511, 525-526.

HHS predicted that new providers would join the program to make up for the loss of existing providers, a prediction the stay order credited. *See* ER68-69; AOB40; Stay Order at 23. But as the district court observed, "this claim is not backed by any discernible evidence or analysis." ER29. Pressed on this point at oral argument in the district court, HHS's counsel asserted that it was "just intuitive" that new providers would replace departing ones because of the "fluid marketplace" for medical services. ER30. That is unsupported speculation, not reasoned analysis.

Nor does HHS cite any record evidence that new providers will enter the program. It argues that "honoring statutory protections of conscience in Title X may increase the number of providers in the program" (AOB40), but HHS has since acknowledged in court filings that "preexisting policy dating back at least to 2008" already allows for such protections. SER2. Yet there is no evidence of an influx of new providers that could make up for the volume of anticipated departures under the rule. And at any rate, HHS did not need to promulgate the rule to adopt religious accommodations, which are wholly unrelated to the physical separation requirement.

HHS also argues the physical separation requirement is necessary because "physical collocation" of a Title X clinic and an abortion clinic "would impermissibly subsidize abortion." AOB38. The district court found no evidence in the record to support this claim either. ER59. On the contrary, the fact that many providers intend to leave the Title X program rather than comply with the physical separation requirement, *see infra* at 55-56, suggests that if anything non-program activities may be subsidizing Title X programs, which even with the grants are generally not lucrative for providers.

2. The Counseling Restrictions

The district court also determined that HHS had not adequately justified its decision to adopt the restrictions on abortion counseling, including referrals. ER70-71. The court noted that those restrictions were not necessary to comply with federal conscience protections, *id.*, which HHS now concedes is correct, AOB37; *see supra* at 50. The district court also reasoned that the restrictions are premised on factual assertions that directly "contradict those which underlay the 2000 regulations," yet HHS failed to explain its change in position. ER71.

The *only* justification HHS offers for these restrictions is its view "that the best reading of §1008" requires them. AOB37. But, again, *Rust* held that the statute "does not speak directly to the issues of counseling [and] referral." 500 U.S. at 184. Even if HHS's interpretation remained a permissible one, a reasoned

analysis to support this substantial change in policy would still be required—especially in light of the uncontroverted evidence that the restrictions will cause many existing providers to leave the program. HHS has failed to provide one.

3. The "Physician or Advanced Practice Provider" Requirement

The district court held that HHS had inadequately justified the rule's requirement that only "physicians or advanced practice providers" (APPs) may engage in nondirective pregnancy counseling. ER72. "The agency … did not address voluminous evidence that non-APP personnel with the proper training have long been capably providing pregnancy counseling," as HHS itself recognizes. ER72; *see* 84 Fed. Reg. at 7778 (noting that non-APPs participated in 1.7 million Title X visits in 2016, approximately a quarter of the total). The requirement will reduce the volume of patients Title X providers can serve. SER155-156, 472-480, 535.

HHS does not explain why it believes the district court's analysis was wrong. AOB41-42. It faults the district court for "disregarding" the agency's reasoning (AOB42), but the court discussed the two rationales HHS offered: that "the Final Rule is more permissive than the proposed Rule" (which restricted pregnancy counseling to physicians only) and that HHS "reasonably drew the line at APPs, who have 'advanced medical degrees, licensing, and certification requirements.'" ER72. The district court reasoned that the first rationale did not "explain *why*

pregnancy counseling should be limited to physicians or APPs," and that the second rationale "merely recites the Final Rule's definition of APP" and likewise did not "explain[] *why* 'advanced medical degrees, licensing, and certification requirements' are necessary to qualify someone to provide pregnancy counseling. *Id.* HHS offers no grounds for reversing those conclusions.

4. The Removal of the "Medically Approved" Requirement

The district court determined that HHS had inadequately justified its decision to remove the requirement that the "family planning methods … and services" offered by Title X programs be "medically approved." ER73. HHS stated that the requirement "risked creating confusion about what kind of approval is required," 84 Fed. Reg. at 774, but as the district court noted, there is no evidence that any provider had expressed any confusion: It was widely understood that "medically approved" means "contraceptive methods that have been approved by the Food and Drug Administration," in accordance with HHS's own guidance. ER73.

HHS deemed the requirement unnecessary because, in its view, "it is true of all family planning methods or services … that at least one medical professional or clinic has 'approved' the method or service." 84 Fed. Reg. at 7732. But as the district court determined, it was arbitrary and capricious for HHS to "disregard[] the industry-accepted understanding of 'medically approved'" in favor of a rule "that a single individual—who may be but is not necessarily a 'licensed health care

professional'—may be able to confer medical approval." ER74. Nothing in HHS's brief rebuts that conclusion.

5. The Department's Cost-Benefit Analysis

The district court also concluded that HHS performed an inadequate cost-benefit analysis. ER75-83. The court concluded that "the agency proclaimed that a myriad of benefits would flow from the Final Rule without providing any substantiating basis or analysis," while "dismiss[ing] out of hand evidence of the significant costs the Final Rule is likely to inflict." ER76. Apart from the discussion of this issue in the context of the physical separation requirement, *see supra* at 48-49, HHS again offers nothing to dispute the district court's thorough reasoning.

II. The District Court Did Not Abuse Its Discretion in Concluding that the Other Preliminary Injunction Factors Favor the Plaintiffs

Apart from the likelihood of success on the merits, HHS contends that the district court abused its discretion in determining that the other preliminary injunction factors favored the plaintiffs. AOB42-47. It did not.

A. The Rule Will Cause Irreparable Harm to California

The district court found that, unless enjoined, the rule would cause irreparable harm to California and its residents during the time it takes to litigate this case. ER22-27. In several respects, the rule will adversely affect public health and public finances in the State in a manner that cannot be rectified by a later court

judgment. *See Harris v. Bd. of Supervisors*, 366 F.3d 754, 766 (9th Cir. 2004) (injury to public health may constitute irreparable harm warranting a preliminary injunction).

First, the rule's restrictions on abortion counseling (including referrals), and its mandate that Title X providers refrain from including reproductive healthcare specialists or even identifying which providers on a list given to the patient provide abortion, will cause many Title X patients who want to obtain an abortion to be delayed in doing so. ER23. Abortion is a time-sensitive procedure, and the medical risks and costs associated with it "increase with any delay." SER158.

Separately, the district court found that the rule "threatens to drastically reduce access" to Title X services "by driving large numbers of providers out of the program." ER23. That is because many providers "have indicated that they will likely drop out of the program because they believe the Final Rule compels them to compromise the quality of care they provide and violate their ethical obligations." ER23-24; *see* SER509, 543, 547, 561. Together, these providers serve more than three quarters of all Title X patients in California. ER24; see SER509. Loss of Title X funding will force providers to reduce the number of patients they serve, as well as curtailing critical outreach and education programs. ER24; *see* SER509-510, 541-543, 570-571, 583, 589-591. Likewise, the rule's mandate that only physicians and advanced practice providers may provide

pregnancy counseling will exclude "vast numbers of medical professionals" who currently do so, further reducing access to services. ER25; *see* SER155-156, 512, 547-548.

These concerns are particularly acute because of the importance of the current Title X program to public health. Title X programs help fund access to more than 1.5 million office visits per year for low-income Californians, in addition to hundreds of thousands of Pap tests, breast exams, and HIV and STI screenings. ER25; SER56, 589-590, 595, 600. That access is critical for rural patients in particular, for whom current Title X programs may be the only accessible family planning services. ER25; SER504-505, 556, 563-564. And even where alternative providers are available, the district court credited evidence showing that existing Title X providers offer higher quality care because they "use more effective contraceptive methods at higher rates than those served by non-Title X-funded providers." ER25; SER510. Reduced access to and lower quality of family planning services resulting from the rule will lead to worse health outcomes for patients, an increase in unintended pregnancies (which tend to have higher rates of adverse maternal and child outcomes than planned pregnancies) and STIs, and a decrease in rates of early diagnosis and treatment of conditions such as breast and cervical cancer. ER26; SER52-54, 56-58, 154, 525-526.

This public health harm, in turn, will cause economic harm to California. The State's Medicaid program, Medi-Cal, provides health insurance to many low-income residents, including covering 64% of unplanned births in California. ER27; SER558-562. Each unintended pregnancy covered by Medi-Cal costs the State more than $6,500 in medical and other social service costs. ER27; SER558. The State would also bear costs resulting from delays in the diagnosis and treatment of STIs and cancer. ER27; SER527. Because these costs would not be recoverable in monetary damages, they constitute irreparable harm. *California v. Azar*, 911 F.3d 558, 581 (9th Cir. 2018).

HHS's contrary arguments are meritless. It asserts that the district court wrongly dismissed "the Department's expert prediction" that new providers would "fill any gaps" left by the departure of existing providers from Title X. AOB43. But the district court reasoned that that conjecture was "not backed by any discernible evidence or analysis," ER29, and HHS provides none—let alone evidence suggesting that enough new providers would join to make up for the significant number of provider departures if the rule takes effect. HHS also contends that providers' compliance costs "cannot establish irreparable harm." AOB43. But the authorities HHS cites suggest only that compliance costs *alone* may not be irreparable harm; they do not establish that irreparable harm is not present where (as here) increased costs lead to adverse public health outcomes.

Moreover, apart from compliance costs, many providers will withdraw from Title X because the rule requires them to compromise the quality of care they offer and violate ethical standards. *Supra* at 55.

B. The Balance of Equities and Public Interest Favor an Injunction

The balance of equities and public interest also favor enjoining the rule. ER32-33; *see Drakes Bay Oyster Co. v. Jewell*, 747 F.3d 1073, 1092 (9th Cir. 2014). HHS argues that the balance of equities disfavors an injunction because "the government sustains irreparable harm whenever" a court enjoins it from enforcing a statute through regulation. AOB45. But this Court has rejected that very argument. *See E. Bay Sanctuary Covenant v. Trump*, 909 F.3d 1219, 1254 (9th Cir. 2018); *Washington v. Trump*, 847 F.3d 1151, 1168 (9th Cir. 2017) (per curiam).

HHS also argues that the injunction supposedly imposes "administrative burdens" and "uncertainty." AOB45. But the injunction merely keeps the prior regulatory regime, in effect for nearly two decades, in place. The federal government generally does not suffer irreparable harm from an injunction that "temporarily restore[s] the law to what it had been for many years" pending adjudication of the challenged action. *E. Bay Sanctuary Covenant*, 909 F.3d at 1255; *see Feldman v. Ariz. Sec'y of State's Office*, 843 F.3d 366, 369 (9th Cir. 2016) (en banc) (no irreparable harm where injunction "restores the *status quo*

ante" of the state's "long standing … procedures"). Here, on the contrary, it is immediate implementation of the new rule, subject to possible later reversal if California and others ultimately prevail, that would create massive uncertainty and impose large and wholly avoidable costs.

HHS's other arguments regarding administrative burden are meritless. It asserts that it is "unable to provide guidance to current grantees about the applicable requirements" (AOB45), but nothing prevents it from explaining to grantees (if the injunction is restored) that the status quo remains in place pending resolution of lawsuits challenging the rule. HHS also asserts that certain "grantees may be deterred from entering the program" with the new rule enjoined (AOB45), but as noted above, HHS has determined that these grantees' concerns can be accommodated under preexisting law, *supra* at 50.

C. The Injunction Is Not Overbroad

Finally, HHS argues in passing that the "injunction's scope is overbroad" because it encompasses certain provisions of the rule HHS contends are severable. AOB46-47. That charge is unfounded. Where the district court determined that its reasoning required the invalidation of multiple provisions, it explained why. *See* ER42-43, 52-54. The district court tailored the injunction in other respects as well. It excluded from the injunction two provisions of the rule (42 C.F.R. §§59.3 and

59.5(a)(13)) that it determined remained valid, ER3-4, and limited the scope of the injunction to California, ER84-86.

Apart from one specific provision it failed to raise in the district court—regarding a situation in which a woman's employer objects to providing employees with health insurance covering contraceptives, AOB46-47; *cf.* SER17—HHS does not identify which provisions the district court erroneously enjoined. It is not this Court's job to do so. "Inadequately briefed and perfunctory arguments are … waived," *Cal. Pac. Bank v. FDIC*, 885 F.3d 560, 570 (9th Cir. 2018), as are arguments "raised for the first time on appeal," *Li v. Kerry*, 710 F.3d 995, 1000 & n.4 (9th Cir. 2013).

III. The Stay Order Issued by the Motions Panel Does Not Control this Court's Resolution of the Issues

As discussed above, the motions panel endorsed several of the positions advanced by HHS. In considering this appeal, however, this Court is not obligated to reach the same conclusions. As the motions panel recognized, its task was to determine whether HHS "is *likely to prevail* on its challenge to the district courts' preliminary injunctions." Stay Order at 13 (emphasis added). The question whether those injunctions should be affirmed is now squarely before this Court, and the motions panel's *prediction* regarding this Court's likely resolution of that appeal is not controlling. "[W]hile a merits panel does not lightly overturn a

decision made by a motions panel during the course of the same appeal," it is not bound to follow it. *United States v. Houser*, 804 F.2d 565, 568 (9th Cir. 1986).[6]

That rule is sensible in the context of this case, where the motions panel issued the stay order after abbreviated briefing and without oral argument—after HHS had filed its principal brief in this appeal, but before California and the other plaintiffs had done so. That is common in the stay context, often by necessity. The purpose of a stay is simply to "hold [a] matter under review in abeyance because the appellate court lacks sufficient time to decide the merits." *Leiva-Perez v. Holder*, 640 F.3d 962, 967 (9th Cir. 2011). Even more so than a preliminary injunction appeal, a stay motion is not an occasion for resolving the underlying merits of a lawsuit. "Such pre-adjudication adjudication would defeat the purpose of a stay, which is to give the reviewing court the time to 'act responsibly,' rather than doling out 'justice on the fly.'" *Id.* (quoting *Nken v. Holder*, 556 U.S. 418, 427 (2009)).

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[6] This Court's opinion in *Lair v. Bullock*, 798 F.3d 736, 747 (9th Cir. 2015), is not to the contrary. There, a prior motions panel—itself following binding circuit precedent—had squarely held that an earlier Supreme Court decision had no majority opinion and set no precedent. *Lair v. Bullock*, 697 F.3d 1200, 1205-06 (9th Cir. 2012). The merits panel in the second *Lair* case followed that precedent as well. 798 F.3d at 747. *Lair* should not be read to hold that a merits panel in this case is bound by the predictive judgments or "on the fly" reasoning of a motions panel under the different circumstances of this case.

California acknowledges, however, that this Court's law regarding the relationship between a published motions panel opinion and a later three-judge panel in the same case confronting similar questions of law appears unsettled. Thus, to the extent this Court believes that the stay order may affect a three-judge panel's resolution of the issues presented, California respectfully seeks initial hearing of this appeal by the en banc court pursuant to Federal Rule of Appellate Procedure 35, as discussed in its concurrently filed petition.

CONCLUSION

The Court should affirm the district court's order entering a preliminary injunction.

Dated: July 1, 2019

Respectfully submitted,

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STATEMENT OF RELATED CASES

The following known related cases are pending in this Court: *Oregon v. Azar*, No. 19-35386, and *Washington v. Azar*, No. 19-35394. These cases raise the same or closely related issues as this case does. *See* Circuit Rule 28-2.6(c).

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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