Nos. 19-15974 & 19-15979

IN THE

United States Court of Appeals

FOR THE NINTH CIRCUIT

STATE OF CALIFORNIA,

Plaintiff-Appellee,

v.

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

Defendants-Appellants,

ESSENTIAL ACCESS HEALTH, INC., et al.,

Plaintiffs-Appellees,

v.

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

Defendants-Appellants,

On Appeal from the United States District Court
for the Northern District of California

BRIEF OF AMICUS CURIAE NATIONAL CENTER FOR YOUTH LAW IN SUPPORT OF PLAINTIFFS-APPELLEES

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STATEMENT OF INTEREST PURSUANT TO RULE 29

The National Center for Youth Law ("NCYL") is a non-profit law firm dedicated to protecting the rights of children and improving the systems that affect their lives. For over 45 years, NCYL has led high-impact initiatives that combine research, policy advocacy, and litigation with the goal of ensuring that all children receive the support they need to thrive, and to which they are entitled.

As part of its adolescent-health agenda, NCYL supports access for all children to quality reproductive health care. Title X of the Public Health Service Act, 42 U.S.C. § 300 et seq., is a key mechanism for such access. Since its enactment in 1970, Title X has made quality reproductive health care available to countless young people. The program is especially important for populations that have historically faced inequities in health care access and outcomes, such as adolescents who are of color, in foster care, or homeless.

The government's proposed changes to Title X (the "Final Rule") would sharply reduce adolescents' access to quality reproductive health care, causing them irreparable harm. As an amicus curiae, NCYL submits this brief to explain why.[1]

[1] Pursuant to Fed. R. App. P. 29(a)(2), all parties to the appeal consent to NCYL filing this amicus curiae brief. As required by Fed. R. App. P. 29(a)(4)(E), counsel certifies that this brief was not authored, in whole or in part, by counsel to a party, and further, that no person or entity other than amicus curiae, its members, or its counsel made any monetary contribution to the preparation or submission of this brief. For the Court's convenience, NCYL notes that this brief is identical in

INTRODUCTION

Health centers funded by Title X provide comprehensive family-planning services to low-income communities. Adolescents, in particular, are among the program's primary beneficiaries. In recent decades, Title X health centers have waged an overwhelmingly successful campaign against unintended teen pregnancy and sexually transmitted infections ("STIs"). Much of this campaign's success owes to Title X's directive that all patients be given access to "a broad range" of contraceptive methods so that they can determine for themselves which methods best meet their needs.[2] Adolescents who have access to the contraceptive method of their choice are more likely to use it consistently and correctly, thereby minimizing the risk of unintended pregnancy and STIs.

The Final Rule is at odds with Title X's purpose and will have dramatic, negative consequences for adolescents. Some of these consequences will be immediate: many health centers will restrict their services or close altogether, which for many adolescents will put reproductive healthcare out of reach. In the patchy health-care landscape that remains, the Final Rule will erode the quality of care at remaining Title X health centers by permitting them to designate medically

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substantive content to the briefs it is submitting in Case Nos. 19-35386 & 19-35394, also relating to the Final Rule.

[2] 42 U.S.C. § 300(a) (2012).

*un*approved methods of family planning—for example, abstinence-only education and so-called natural family planning ("NFP")—as their *exclusive* offerings.

The Final Rule will also produce grave consequences in the long term. Rates of unintended teen pregnancy, abortion, and STIs will increase, leading to unnecessary suffering and taxpayer expense. The deliberately inefficient system created by the Final Rule will also undermine trust in medical professionals and public institutions among adolescents who are just beginning to navigate the health care system as adults. And the cycle of poverty in the United States will be reinforced.

ARGUMENT

I. Title X Is Critical For Adolescents' Access To Comprehensive Family Planning And Related Health Services

Since its passage in 1970, Title X has been the only federal program devoted solely to family-planning services.[3] Congress enacted Title X specifically to bring comprehensive family planning and other health services to low-income, vulnerable, and remote populations.[4] Some of the fundamental objectives of the program are to

[3] *See* OFFICE OF POPULATION AFFAIRS, *Funding History*, *available at* https://perma.cc/7RLY-2VWU ("Title X is the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services.") (last updated Apr. 4, 2019).

[4] *See* OFFICE OF POPULATION AFFAIRS, *Fiscal Year 2019 Program Priorities*, *available at* https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/program-priorities/index.html.

expand access to family planning for young people and prevent unintended adolescent pregnancies.[5] Title X is currently the only federal stream of dollars dedicated to family-planning services for young, low-income women.[6] In 2017, roughly 20% of the 4 million patients treated at Title X health centers were aged 19 or younger.[7]

Low-income, uninsured, and underinsured young people are among Title X's primary beneficiaries for a variety of reasons. Title X health centers currently exist in most counties in the United States.[8] As a result, they are more accessible to youth who are without transportation or who live in rural or remote areas. Title X health

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[5] *See supra* note 2, § 300(a) (requiring Title X projects to offer "a broad range of acceptable and effective family planning methods and services (including…services for adolescents)"); *Planned Parenthood v. Heckler*, 712 F.2d 650, 652 (D.C. Cir. 1983) (finding that 42 U.S.C. § 300(a) "clearly reflect[s] Congress' intent to place a 'special emphasis on preventing unwanted pregnancies among sexually active adolescents'") (quoting S. Rep. No. 822, 95th Cong., 2d Sess. 24 (1978)).

[6] Lawrence B. Finer & Stanley K. Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38 PERSP. ON SEXUAL & REPROD. HEALTH 90, 95 (2006), *available at* https://perma.cc/A3NP-EJB9.

[7] *See* ANGELA NAPILI, CONG. RESEARCH SERV., R45181, FAMILY PLANNING PROGRAM UNDER TITLE X OF THE PUB. HEALTH SERV. ACT 15 (2018), *available at* https://perma.cc/J4XX-ND47.

[8] In 2008, Title X services were available in 75% of all United States counties via more than 4,500 community-based clinics, hospitals, university health centers, government health departments, and other agencies. *See* CHRISTINA FOWLER ET AL., OFFICE OF POPULATION AFFAIRS, TITLE X FAMILY PLANNING ANNUAL REPORT: 2008 NAT'L SUMMARY 7 (2009), *available at* https://perma.cc/8QJ4-ZLQJ.

centers are also essential for young people because they offer low-cost services and require no co-pay.

Notably, unlike many state laws, Title X allows adolescents to give consent on their own behalf—in lieu of consent from a parent or legal guardian—when receiving family-planning services.[9] Although most minors can and do involve their families in their reproductive health decisions, the ability of minors to consent to their own care at Title X centers ensures that they receive immediate access when needed. This is especially true for youth who are homeless, in foster care, or experiencing domestic abuse. For them, Title X is often the difference between obtaining health care and not.

The family-planning services available to adolescents at Title X clinics are sorely needed. Despite the progress made in recent years, the United States still has one of the highest adolescent pregnancy rates in the developed world. Roughly 700,000 young people between the ages of 15 and 19 become pregnant each year,[10]

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[9] *See* 42 C.F.R. § 59.5(a)(4) (requiring Title X services to be provided without regard to age); *Cty. of St. Charles v. Mo. Family Health Council*, 107 F.3d 682, 684–85 (8th Cir. 1997) (providing that parental consent is not a prerequisite in order for a minor to receive Title X services); *Does 1-4 v. Utah Dep't of Health*, 776 F.2d 253, 255–56 (10th Cir. 1983) (same).

[10] *See* Loretta Gavin et al., *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*, CTR. FOR DISEASE CONTROL & PREVENTION MORBIDITY & MORTALITY WKLY. REP. at 1 (Apr. 25, 2014), *available at* https://perma.cc/EPB9-X5N5.

and half of all new STIs are in young people between the ages of 15 and 24.[11] Youth who are of color, homeless, and in foster care suffer disproportionately high rates of unintended teen pregnancy and STIs.[12] For instance, homeless young women are almost five times more likely than others to become pregnant,[13] and half of female adolescents in foster care experience pregnancy by the age of 19.[14]

Despite suffering high rates of unintended pregnancy and STIs, adolescents have limited access to information about reproductive health care.[15] In order to address this problem, Title X has historically mandated that providers offer a broad range of medically approved contraception. Eighteen contraceptive methods are available to adolescents.[16] Of these, long-acting reversible contraception ("LARC"),

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[11] *See* CTR. for DISEASE CONTROL & PREVENTION, *Information for Teens: Staying Healthy and Preventing STDs* (2017), *available at* https://perma.cc/65UH-U8YJ.

[12] *See, e.g.*, Sigrid James et al., *Sexual Risk Behaviors Among Youth in the Child Welfare System*, 31 CHILDREN & YOUTH SERVS. REV. 990–1000 (2010), *available at* https://perma.cc/4KA9-SEXP; Marcela Smid et al., *The Challenge of Pregnancy among Homeless Youth: Reclaiming a Lost Opportunity*, 21 J. HEALTH CARE POOR & UNDERSERVED 140–56 (2010), *available at* https://perma.cc/8D2W-QGQA.

[13] *See* Marcela Smid et al., *supra* note 12 at 141.

[14] Mark E. Courtney et al., *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 19*, CHAPIN HALL CTR. FOR CHILDREN AT THE U. CHI. (2005), *available at* https://perma.cc/2D3V-4DM6.

[15] Sigrid James et al., *supra* note 12 at 1001.

[16] *See* PLANNED PARENTHOOD FED'N OF AM., *Birth Control*, *available at* https://perma.cc/R829- LD3W (last visited July 3, 2019).

such as intrauterine devices and implants, have proved especially beneficial. LARCs are the most effective form of reversible contraception, with a failure rate of less than 1%, compared to 9% for oral contraceptives, the patch, or the birth control ring.[17] LARCs also eliminate the risk of user error because they do not require regular maintenance.[18]

Despite their advantages, LARCs can be difficult to access for many young people because of their high up-front costs.[19] Title X is therefore critical to ensuring that this exceptionally effective, low-maintenance method of contraception is an affordable option for adolescents.

Over the past decade, experience with LARCs has increased markedly amongst young people.[20] LARCs are particularly important for youth in precarious living conditions, such as those who are homeless, in foster care, or victims of domestic and sexual abuse. Youth in these circumstances often have limited control

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[17] Riley J. Steiner et al., *Long-Acting Reversible Contraception and Condom Use Among Female U.S. High School Students: Implications for Sexually Transmitted Infection Prevention*, 170 J. OF AM. MED. PEDIATRICS 428–34 (2016), *available at* https://perma.cc/7R6H-KBUP.

[18] Unlike with routine injections or oral contraception, once a LARC has been inserted, the patient need not take any further action. *See id.*

[19] Kelly Cleland et al., *Family Planning as a Cost-Saving Preventive Health Service*, 364 NEW ENG. J. OF MED. e37, e37(2) (2011), *available at* https://perma.cc/3M92-35HZ.

[20] *See* AAP Committee on Adolescents, *Contraception for Adolescents*, 134 PEDIATRICS 1257, 1281 (2014), *available at* https://perma.cc/C9WU-9U3W.

over their reproductive decisions. For example, a teenager in foster care who experiences frequent changes in her home placement might be unable to regularly fill a birth-control prescription at a health clinic. Young people living hours away from the nearest health center may lack the financial means to travel to medical appointments.[21] By offering adolescents their personal choice of contraception, including LARCs, Title X facilities give them an important measure of control and agency over their reproductive health.

To be clear, LARCs may not be the preferred option for every adolescent. For example, LARCs do not protect against STIs.[22] And young people, particularly if they feel uncomfortable with a medical implant, might opt for other contraceptive methods based on their personal preferences and circumstances. For these reasons, it is imperative that Title X health centers continue to offer a range of contraceptive methods to meet the unique needs of each adolescent. Indeed, Title X's requirement that providers offer diverse contraceptive options has already proved its value, as rates of unintended teen pregnancy, abortion, and STIs have dramatically declined in recent years.[23]

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[21] *See* Christian M. Connell et al., *Changes in Placement Among Children in Foster Care: A Longitudinal Study of Child and Case Influences*, 80 SOC. SERV. REV. 398–418 (2006), *available at* https://perma.cc/C6SS-4EJ7.

[22] *See* Riley J. Steiner et al., *supra* note 17.

[23] *See* OFFICE OF ADOLESCENT HEALTH, U.S. DEP'T OF HEALTH & HUMAN SERVS., *Trends in Teen Pregnancy and Childbearing* (June 2, 2016), *available at*

II. The Final Rule Will Drastically Curtail Adolescents' Access To Basic Reproductive Health Care

Contrary to Title X's purpose, the Final Rule will jeopardize youth's access to quality reproductive health care in two principal ways. First, it will cause clinics to close or offer reduced services, creating a desert of affordable family-planning services for adolescents. Access to affordable reproductive health care in some parts of the country will simply cease to exist. Second, the Final Rule will reduce the effectiveness of surviving Title X facilities and subject adolescents to lower standards of care, including methods of family planning that lack medical approval. The resulting harm to adolescents will be irreparable.

A. Clinic Closures And Reductions In Services Will Put Quality Reproductive Health Care Beyond The Reach Of Many Adolescents

The Final Rule will create a piecemeal health-care landscape that restricts access to family-planning services for young people. Current Title X providers would be incentivized to leave the program because of the Final Rule's cost-prohibitive provisions. Absent Title X funding, these health centers would be forced to limit their services significantly or shut down altogether. Consequently, as described below, adolescents would face significant barriers to accessing local, affordable, and quality reproductive health care.

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https://perma.cc/8SW4-2HV4 ("The national teen pregnancy rate has declined almost continuously over the last quarter century.").

The "physical separation" requirement illustrates the cost-prohibitive effect of the Final Rule. According to the Final Rule, a Title X project must "be organized so that it is physically…separate" from abortion-related activities.[24] Implementing this provision would involve enormous expenditures of time and money. Title X providers would have to create so-called "mirror" facilities, equipped with separate examination and waiting rooms, entrances and exits, workstations, educational services, health records, websites, and signs.[25] Faced with these additional, unnecessary requirements, health centers that are already under-funded, under-staffed, and under-resourced would be forced out of the Title X network.

By way of example, Planned Parenthood has stated unequivocally that it will be "forced to discontinue [its] participation in Title X" if the Final Rule takes effect.[26] Planned Parenthood currently serves 40% of all Title X patients

[24] 42 C.F.R. § 59.15 (2019).

[25] The Final Rule outlines a number of factors to determine whether Title X projects are sufficiently separate from abortion-related activities, including but not limited to: (1) the "degree of separation [of] facilities," such as between examination and waiting rooms, office entrances and exits, educational services, and websites; (2) the existence of "separate personnel, electronic, or paper-based health records, and workstations"; and (3) the extent to which separate signs, forms, and materials reference Title X projects versus abortion-related activities. *Id.*

[26] *California v. Azar*, No. 19-cv-01184-EMC, 2019 WL 1877392, at *9 (N.D. Cal. Apr. 26, 2019).

nationwide, including an estimated 2.8 million women, men, and young people.[27] Without Title X funds, providers such as Planned Parenthood will be forced to reduce clinic hours and services, eliminate staff positions, and close satellite sites altogether. Youth visiting these facilities risk losing low-cost services and may be required to provide a copay. Fewer medical appointments would be available to adolescents due to staffing shortages and limited clinic hours. And adolescents in some states would lose the ability to consent to their own care.

If the Final Rule is implemented, the scarcity of remaining Title X centers will impose additional barriers between young people and affordable reproductive health care. Youth, particularly in remote or rural areas or who lack transportation, would be required to travel even longer distances to visit a Title X facility. Many adolescents may not have cars readily available, and even so, most cannot obtain driver licenses until at least the age of sixteen. Moreover, young people might not feel comfortable driving or taking public transportation over long distances, including across whole states and regions.

Even assuming that adolescents can reach a Title X facility, the strain on remaining providers will further limit their access to high-quality reproductive health care. For example, if Planned Parenthood is forced out of Title X, other Title X

[27] *Id.* at *33; *see also* PLANNED PARENTHOOD FED'N OF AM., *By the Numbers* (2018), *available at* https://perma.cc/EX8G-2C5C.

programs will have to "increase their client caseloads by 70 percent, on average."[28] In light of the pressure on existing Title X providers, adolescents will have fewer family-planning services and resources available to them as a result of the Final Rule.

B. Medically Unapproved Methods Of Family Planning And A Retreat From Non-Directive Counseling Will Lower Standards Of Care For Adolescents At Remaining Title X Facilities

Title X facilities that survive the Final Rule will additionally be held to a lower standard of care. The Final Rule promotes medically unapproved methods of family planning that will lead to more unintended teen pregnancies and STIs. It also requires doctors to respond to questions about abortion with silence or obfuscation instead of with medical facts and forthright, non-directive counseling. Both of these changes will further curtail adolescents' access to high-quality, comprehensive reproductive healthcare.

One of the most disturbing aspects of the Final Rule is that it dispenses with the perennial, commonsense requirement that all Title X facilities provide family-planning methods that are "medically approved." Until now, Title X has required each facility to "[p]rovide a broad range of acceptable and effective *medically*

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[28] *See* Jennifer J. Frost & Mia R. Zolna, *Response to Inquiry Concerning the Impact on Other Safety-Net Family Planning Providers of "Defunding" Planned Parenthood*, GUTTMACHER INSTITUTE, 2 (June 2017), *available at* https://perma.cc/H9G9-WQSG.

approved family planning methods."[29] But the Final Rule strikes the "medically approved" language from this provision.[30] And it also does not require each facility to offer a "broad range" of family-planning methods.[31] Instead, the Final Rule allows a facility to "offer only a single method" of family planning as long as it is part of a *network* of facilities that, on the whole, "offer a broad range" of methods.[32] Because a network can span whole states and even regions, large swaths of the country could therefore be left with Title X clinics that offer only *a single, medically unapproved method of family planning*. This is a plain abrogation of the government's responsibility under Title X to ensure access to evidence-based care and "a broad range" of effective family planning methods for all adolescents.[33]

The medically *un*approved methods of family planning contemplated by the Final Rule include abstinence-only education and "natural family planning," neither of which is effective at preventing unintended teen pregnancy or STIs.[34] A recent study found that abstinence-only education does not reduce the rate of teen

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[29] 42 C.F.R. § 59.5(a)(1) (2000) (emphasis added).

[30] 42 C.F.R. § 59.5(a)(1) (2019).

[31] *Id.*

[32] *Id.*

[33] *Supra* note 2, § 300(a).

[34] *See supra* note 30, § 59.5(a)(1) (identifying "natural family planning" specifically).

pregnancy or STI transmission at all.[35] Abstinence-only education also incorrectly assumes that all adolescents can choose if and when they have sex. Adolescents who are homeless or in foster care, in particular, suffer a disproportionately high incidence of rape. A recent study reports that approximately 15% of female minors in foster care are raped by age 17.[36] The statistics for homeless youth are no better: roughly a quarter to a third are sexually abused before becoming homeless,[37] and approximately 15% more are raped or sexually assaulted on the street.[38] In addition, more than a third of female homeless youth engage in "survival sex"— the exchange of sex for basic necessities like shelter, food, or protection.[39] Abstinence-only education does nothing to protect these vulnerable youth from unintended pregnancy or STIs.

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[35] John S. Santelli et al., *Abstinence-Only-Until-Marriage: An Updated Review of U.S. Policies and Programs and Their Impact*, 61 J. ADOLESCENT HEALTH 273–80 (2017), *available at* https://perma.cc/849E-HTKR.

[36] Mark E. Courtney et al., *Findings from the California Youth Transitions to Adulthood Study (CalYOUTH): Conditions of Youth at Age 19*, CHAPIN HALL CTR. FOR CHILD. AT THE U. CHI. (2016), *available at* https://perma.cc/M4VA-A4VB.

[37] JODY M. GREENE ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., SEXUAL ABUSE AMONG HOMELESS ADOLESCENTS: PREVALENCE, CORRELATES, & SEQUELAE 5-18 (2002), *available at* https://perma.cc/M67J-CYKA.

[38] LES WHITBECK ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., DATA COLLECTION STUDY FINAL REP. 3, 33 (2016), *available at* https://perma.cc/2MR9-G96Z.

[39] *Id.* at 45, 47.

NFP is likewise an ineffective family-planning method for adolescents. NFP is based on the timing of sex during a woman's menstrual cycle. As typically practiced, it results in pregnancy at a rate of approximately 30 times that of LARCs and 2.6 times that of oral contraceptives.[40] NFP requires disciplined, daily attention and, in some instances, fragile and expensive equipment, such as thermometers and electronic hormonal fertility monitors.[41] Its success also depends on cooperative male partners who are willing to refrain from intercourse during fertile periods that typically last more than a week at a time.[42] NFP is a challenging method of family planning even for adults in healthy relationships. For adolescents who are homeless, sexually abused, or facing other unstable living situations, NFP is an impractical option. It also offers no protection against STIs.

The Final Rule would further harm adolescents by abandoning the longstanding requirement that Title X providers offer non-directive counseling about abortion. To be clear, Title X providers have never offered abortion care. The Final Rule, however, would prohibit a Title X provider from candidly *discussing* abortion care with a patient seeking such information. Under the Final Rule, Title X providers

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[40] U.S. DEP'T OF HEALTH & HUMAN SERVS., EFFECTIVENESS OF FAMILY PLANNING METHODS, https://perma.cc/QXR5-JHM7 (last visited June 30, 2019).

[41] The American College of Obstetricians & Gynecologists, *FAQ 024: Fertility Awareness-Based Methods of Family Planning* (Jan. 2019), *available at* https://perma.cc/JG7G-7K8Y.

[42] *Id.*

cannot "promote, refer for, or support abortion as a method of family planning, nor take any other affirmative action to assist a patient to secure such an abortion."[43] If a patient asks where she can obtain an abortion, a Title X provider is permitted to respond only with a list of primary-health-care providers, at least half of which must *not* perform abortion.[44] "[N]either the list nor project staff may identify which providers on the list perform abortion,"[45] and the list may even contain *no* providers that perform abortion. The list could be, in other words, entirely non-responsive to the patient's question. Finally, if a patient expressly states that she is seeking abortion care, the Final Rule requires providers to refer her for prenatal care instead.[46] This is the opposite of non-directive counseling.

These requirements are calculated to confuse and mislead adolescents, who generally have limited means to investigate, evaluate, and exercise their reproductive health-care options. Adolescents without easy access to transportation, a phone, and the Internet might be unable to research the providers on the list they are given. They

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[43] 42 C.F.R. § 59.5(a)(5) (2019). In addition, the Final Rule limits the individuals permitted to provide non-directive counseling to "medical professional[s] who receive[] at least a graduate level degree . . . and maintains a license to diagnose, treat, and counsel patients." *Id.* §§ 59.2, 59.14 (2019). This will further limit the availability of non-directive counseling.

[44] *Id.*

[45] *Id.*

[46] *Id.*

also might not immediately comprehend that a medical professional, whom they trust, has referred them for care that they do not need or want. Such needless delays for adolescents who are intent on obtaining an abortion will be frustrating and bewildering. Particularly for adolescents who are homeless or in foster care, navigating a maze of providers that might or might not offer abortion services could prove impossible.

The intentionally inefficient system created by the Final Rule will erode trust, inhibit open and honest communication between adolescents and medical professionals, and impose harmful delays on patients whose medical needs are highly time-sensitive. It is sure to increase the number of later abortions. And it will doubtless sow distrust of institutional authority among adolescents who, as it stands, have few resources when making family-planning decisions.

III. The Final Rule Will Increase Rates of Unintended Teen Pregnancy, Abortion, and STIs, And Cruelly Reinforce The Cycle Of Poverty

Reduced access to contraception leads, as a matter of empirical fact, to more unintended pregnancies and, in turn, more births and abortions. Studies show that rates of unintended teen pregnancy, abortion, and STIs drop when young people have access to a range of contraceptive options.[47] A recent statewide campaign in

[47] *See, e.g.*, Kelly Cleland et al., *supra* note 19; Joanne Noone, *Finding the Best Fit: A Grounded Theory of Contraceptive Decision Making in Women*, 39 NURSING FORUM 13 (2004).

Colorado that increased public access to comprehensive contraception, including LARCs, corresponded with a nearly 50% decline in birth *and* abortion rates among adolescents aged 15 to 19.[48]

The consequences of unintended teen pregnancy reverberate for generations. Children born to teen mothers are significantly more likely than others to grow up in poverty and to become teen parents themselves.[49] They (and their mothers) are also more likely to require public assistance.[50] In 2010, publicly funded, comprehensive family-planning services saved the government an estimated $13.6 billion, representing a sevenfold return on investment.[51] The Final Rule, on the other hand, is likely to increase rates of unintended teen pregnancy and STIs, and will therefore squander a significant investment opportunity.

Numbers cannot, of course, capture the Final Rule's raw human costs. Unintended teen pregnancy and STIs, including HIV, exact a high physical and

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[48] COLO. DEP'T OF PUB. HEALTH & ENV'T, *Taking the Unintended Out of Pregnancy: Colorado's Success with Long-Acting Reversible Contraception* (Jan. 2017), *available at* https://perma.cc/9APG-REC5.

[49] Schuyler Center for Analysis and Advocacy, *Teenage Births: Outcomes for Young Parents and their Children* at 7, 10 (Dec. 2008), *available at* https://perma.cc/M75S-U9LE.

[50] *Id.* at 20.

[51] Jennifer J. Frost et al., *Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program*, 92 THE MILBANK Q. 667 (2014), *available at* https://perma.cc/Z7JH-MMWP.

emotional toll on adolescents. Unintended teen pregnancy is associated with high rates of stress and depression.[52] STIs are associated with increased anxiety symptoms in addition to the well-recognized physical harms.[53] For adolescent girls faced with unintended pregnancy, abortion, or STI infection that would not have occurred but for the Final Rule, the harm will in many cases be irreparable.

CONCLUSION

For the foregoing reasons, the Court should affirm the district court's preliminary-injunction order.

Dated: July 8, 2019

Respectfully Submitted,

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[52] *See* COLO. DEP'T OF PUB. HEALTH & ENV'T, *supra* note 48 at 14 ("Adolescent motherhood can increase the risk of mental health problems, including depression . . . .").

[53] Margaret Coyle et al., *Associations of Depression and Anxiety Symptoms with Sexual Behaviour in Women and Heterosexual Men Attending Sexual Health Clinics: A Cross-Sectional Study*, 95 SEXUALLY TRANSMITTED INFECTIONS 254, 257 (2019), *available at* https://perma.cc/M7KU-JCLV.

STATEMENT OF RELATED CASES

Counsel for Amici National Center for Youth Law are aware of the following related cases pending in this Court:

- *Oregon, et al. v. Azar, et al.* & *Am. Med. Ass'n, et al. v. Azar, et al.*, Case No. 19-35386
- *Washington, et al. v. Azar, et al.*, Case No. 19-35394

Dated: July 8, 2019 *s/ Bina G. Patel*

CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. 29(a)(5), I certify that this brief contains 5,754 words, excluding the parts of this brief exempted by Fed. R. App. P. 32(f). The brief's type size and typeface comply with Fed. R. App. P. 32(a)(5) and (6).

Dated: July 8, 2019 *s/ Bina G. Patel*

CERTIFICATE OF SERVICE

I hereby certify that on July 8, 2019, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system.

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

Dated: July 8, 2019 *s/ Bina G. Patel*