No. 19-1614

IN THE

United States Court of Appeals

FOR THE FOURTH CIRCUIT

MAYOR AND CITY COUNCIL OF BALTIMORE,

Plaintiff-Appellee,

v.

ALEX M. AZAR II, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,

Defendants-Appellants,

On Appeal from the United States District Court
for the District of Maryland

BRIEF OF AMICUS CURIAE NATIONAL CENTER FOR YOUTH LAW IN SUPPORT OF PLAINTIFF-APPELLEE

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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.

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

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[2] 42 U.S.C. § 300(a) (2012).

The Final Rule will also produce grave consequences in the long term. Rates of unintended teen pregnancy 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 expand access to family planning for young people and prevent unintended adolescent pregnancies.[5] Title X is currently the only stream of federal dollars

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[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.

[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

dedicated to family-planning services for young, low-income women.[6] Roughly 20% of the 4 million patients treated at Title X health centers each year are ages 19 or younger.[7] In Maryland each year, Title X health centers serve nearly 12,000 teenagers.[8] In Baltimore alone, these health clinics serve roughly 8,000 Title X patients, of whom nearly 20% are under the age of 18, and more than 80% are female.[9]

Key to the effectiveness of Title X programs has been their *accessibility*. Title X health centers currently exist in most counties in the United States, making them an important source of care for youth who lack access to transportation or live in

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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] *See* GUTTMACHER INSTITUTE, *Publicly Funded Contraceptive Services at U.S. Clinics, 2015* (2017), *available at* https://www.guttmacher.org/sites/default/files/report_pdf/publicly_funded_contraceptive_services_2015_3.pdf.

[9] *Mayor & City of Baltimore v. Azar*, No. RDB-19-1103, 2019 WL 2298808, at *6 (D. Md. May 30, 2019).

remote areas.[10] Another aspect of Title X health centers that makes them especially accessible to young people is that they offer low-cost services and require no co-pay.

Title X also supplies critical funding for many school-based health programs, to which teenage students have ready access. The Baltimore City Health Department, for example, operates three community clinics and four school-based health centers that provide Title X services.[11] All told, over a dozen school-based health programs in Baltimore depend on Title X funding.[12]

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,[13]

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[10] 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.

[11] *See Mayor & City of Baltimore*, *supra* note 9 at *5.

[12] *See* OFFICE OF POPULATION AFFAIRS, *Title X Family Planning Directory* (2019), *available at* https://www.hhs.gov/opa/sites/default/files/Title-X-Family-Planning-Directory-June2019.pdf.

[13] *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.[14] Certain populations of youth, including youth who are of color, homeless, and in foster care, suffer disproportionately high rates of unintended teen pregnancy and STIs.[15] For instance, homeless young women are almost five times more likely than others to become pregnant.[16] And about 50% of female adolescents in foster care experience pregnancy by the age of 19, compared to just 20% in the general population; yet only about a third of these foster youth describe their pregnancies as "definitely or probably wanted."[17]

Despite suffering high rates of unintended pregnancy and STIs, adolescents have limited access to information about reproductive health care.[18] In order to address this problem, Title X has historically mandated that providers offer a broad

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

[15] *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.

[16] *See* Marcela Smid et al., *supra* note 15 at 141.

[17] 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. 53–54 (2005), *available at* https://perma.cc/2D3V-4DM6.

[18] *See id.*; *see also* Sigrid James et al., *supra* note 15 at 1001.

range of medically approved contraception. Eighteen contraceptive methods are available to adolescents.[19] Of these, long-acting reversible contraception ("LARC"), 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.[20] LARCs also eliminate the risk of user error because they do not require regular maintenance.[21]

Despite their advantages, LARCs can be difficult to access for many young people because of their high up-front costs.[22] Title X is therefore critical to ensuring that this exceptionally effective, low-maintenance method of contraception is an affordable option for adolescents.

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

[20] 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.

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

[22] 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.

Over the past decade, experience with LARCs has increased markedly amongst young people.[23] 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 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.[24] 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.[25] 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

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

[24] *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.

[25] *See* Riley J. Steiner et al., *supra* note 20.

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.[26]

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. 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-

[26] *See* OFFICE OF ADOLESCENT HEALTH, U.S. DEP'T OF HEALTH & HUMAN SERVS., *Trends in Teen Pregnancy and Childbearing* (June 2, 2016), *available at* https://perma.cc/8SW4-2HV4 ("The national teen pregnancy rate has declined almost continuously over the last quarter century.").

prohibitive provisions and prohibitions that require health providers to violate ethical standards of practice. 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.

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.[27] 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.[28] 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.

[27] 42 C.F.R. § 59.15 (2019).

[28] 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.*

The Final Rule also places a "gag rule" on licensed medical providers that interferes with their ability to provide competent medical care to patients. Many health centers will opt out of the Title X program rather than violate their ethical duties to patients. By way of example, Planned Parenthood has stated that it is no longer using Title X funds because of the Final Rule.[29] As one of its leaders recently explained, "withhold[ing] important information from patients," as required by the Final Rule, would be "unethical and dangerous."[30] Planned Parenthood serves 40% of all Title X patients nationwide, including an estimated 2.8 million women, men, and young people.[31] Nine Planned Parenthood clinics serve patients in Maryland.[32] Without Title X funds, however, 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. And fewer medical appointments would be available to adolescents due to staffing shortages and limited clinic hours.

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[29] *See* Sarah McCammon, *Planned Parenthood Officials Say They've Halted Use Of Title X Family Planning Funds* (July 17, 2019), https://www.npr.org/2019/07/17/742841170/planned-parenthood-officials-say-theyve-halted-use-of-title-x-family-planning-fu.

[30] *See id*.

[31] *California v. Azar*, No. 19-cv-01184-EMC, 2019 WL 1877392, at *33 (N.D. Cal. Apr. 26, 2019); *see also* PLANNED PARENTHOOD FED'N OF AM., *By the Numbers* (2018), *available at* https://perma.cc/EX8G-2C5C.

[32] *See* OFFICE OF POPULATION AFFAIRS, *supra* note 12.

If the Final Rule is implemented, the scarcity of remaining Title X centers, particularly in Baltimore, will impose additional barriers between young people and affordable reproductive health care. Youth would be required to travel even longer distances to visit a Title X facility since many facilities in Baltimore would no longer be available. Young people might not be able to afford the time or cost of, or feel comfortable with, driving or taking public transportation over long distances by themselves.

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 programs will have to "increase their client caseloads by 70 percent, on average."[33] 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.

[33] *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.

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 approved* family planning methods."[34] But the Final Rule strikes the "medically approved" language from this provision.[35] And it also does not require each facility to offer a "broad range" of family-planning methods.[36] Instead, the Final Rule allows a facility to "offer only a single method" of family planning as long as it is

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[34] 42 C.F.R. § 59.5(a)(1) (2000) (emphasis added).

[35] 42 C.F.R. § 59.5(a)(1) (2019).

[36] *Id.*

part of a *network* of facilities that, on the whole, "offer a broad range" of methods.[37] Because a network can span large regions, many young people could 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.[38]

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.[39] A recent study found that abstinence-only education does not reduce the rate of teen pregnancy or STI transmission at all.[40] 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

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[37] *Id.*

[38] *Supra* note 2, § 300(a).

[39] *See supra* note 35, § 59.5(a)(1) (identifying "natural family planning" specifically).

[40] 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.

in foster care are raped by age 17.[41] The statistics for homeless youth are no better: roughly a quarter to a third are sexually abused before becoming homeless,[42] and approximately 15% more are raped or sexually assaulted on the street.[43] 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.[44] Abstinence-only education does nothing to protect these vulnerable youth from unintended pregnancy or STIs.

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.[45] NFP requires disciplined, daily attention and, in some instances, fragile and expensive equipment, such as thermometers and

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[41] 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.

[42] 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.

[43] 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.

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

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

electronic hormonal fertility monitors.[46] 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.[47] 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 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."[48] If a patient asks where she can obtain an abortion, a Title X provider is permitted to

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

[47] *Id.*

[48] 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.

respond only with a list of primary-health-care providers, at least half of which must *not* perform abortion.[49] "[N]either the list nor project staff may identify which providers on the list perform abortion,"[50] 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.[51] 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 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.

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[49] *Id.*

[50] *Id.*

[51] *Id.*

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.[52] A recent statewide campaign in 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.[53]

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[52] *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).

[53] 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.

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.[54] They (and their mothers) are also more likely to require public assistance.[55] In 2010, publicly funded, comprehensive family-planning services saved the government an estimated $13.6 billion, representing a sevenfold return on investment.[56] 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 emotional toll on adolescents. Unintended teen pregnancy is associated with high rates of stress and depression.[57] STIs are associated with increased anxiety

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[54] 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.

[55] *Id.* at 20.

[56] 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.

[57] *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 . . . .").

symptoms in addition to the well-recognized physical harms.[58] For adolescent girls faced with an unintended pregnancy or STI infection that would not have occurred but for the Final Rule, the harm might well be irreparable.

CONCLUSION

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

Dated: August 5, 2019

Respectfully Submitted,

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[58] 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.

CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. 29(a)(5), I certify that this brief contains 5,797 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: August 5, 2019 *s/ Bina G. Patel*

CERTIFICATE OF SERVICE

I hereby certify that on August 5, 2019, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Fourth 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: August 5, 2019 *s/ Bina G. Patel*