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, et al.,

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, et al.,

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

BRIEF OF THE CALIFORNIA WOMEN'S LAW CENTER AS *AMICUS CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLEES AND AFFIRMANCE

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1, *amicus curiae* California Women's Law Center represents that it does not have any parent entities and does not issue stock.

Dated: July 8, 2019

s/ Theane Evangelis
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INTEREST OF AMICUS CURIAE[1]

Amicus Curiae California Women's Law Center ("CWLC") is a statewide nonprofit law and policy center committed to breaking down barriers and advancing the potential of women and girls through impact litigation, advocacy and education. A vital part of CWLC's mission is fighting for reproductive health rights and justice by ensuring women have access to the health care opportunities they need to lead healthy and productive lives. CWLC believes that women and adolescent girls deserve the right to make choices about their bodies and it is vital to ensure that the full range of reproductive health options are accessible to all women and adolescent girls regardless of their income levels or residence.

CWLC has a direct interest in this case because of the impact the "Final Rule" promulgated by the Department of Health and Human Services ("HHS"), 84 Fed. Reg. 7714 (Mar. 4, 2019), would have on reproductive health care in California and across the country. California's Title X network is the largest in the nation. The Final Rule would significantly impede access to time-sensitive family planning and reproductive health services and disproportionately harm women in rural areas. Health care centers that wish to continue providing abortion counseling and referral

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[1] All parties have consented to the filing of this brief. Fed. R. App. P. 29(a). No counsel for a party authored this brief in whole or in part, and neither the parties, nor their counsel, nor anyone except for the California Women's Law Center financially contributed to preparing this brief. *Id.*

would be forced to forgo Title X funding, thereby reducing the number of family planning clinics accessible to women in rural areas of the state. The Final Rule will also harm women in rural areas who seek far more than just contraceptive care from Title X clinics. CWLC therefore has an interest in opposing the implementation of the Final Rule to ensure that women and adolescent girls in California and around the country continue to have access to the health care opportunities made possible through Title X funding.

ARGUMENT

For decades, Title X-funded health centers have provided essential reproductive health care services to women and adolescent girls all over the United States, including California. The recent rule promulgated by the Department of Health and Human Services ("HHS"), 84 Fed. Reg. 7714 (Mar. 4, 2019) (the "Final Rule"), however, threatens to compromise the network of high-quality care providers many women, particularly those in rural areas, have come to rely on. One of the Final Rule's most pernicious changes is the decision to do away with nondirective pregnancy counseling and referrals. To justify this change, HHS argued—without any real data or evidence in support—that eliminating this requirement might increase the number of applicants for Title X funding, expand the network of providers in rural areas, and improve the quality of the care provided. But there is no evidence that high-quality reproductive health care providers—as opposed to providers that purport to provide counseling services but in fact provide misinformation—will replace the existing providers who have steadily provided care in those communities and will be forced to withdraw from the Title X network due to the Final Rule's new mandates. Without an influx of new providers, those living in rural areas will be left with fewer resources for neutral, nondirective reproductive care.

Specifically, the Final Rule forces Title X clinics that provide comprehensive reproductive health care to decide between forgoing critical Title X funds, which would significantly curtail their ability to provide medical services, ceasing to provide such services altogether, or expending resources to comply with the Rule's onerous and medically unnecessary requirements. Many current Title X providers—particularly those located in rural areas—simply cannot afford to comply with those requirements, which include, among other mandates, that the facilities maintain physical separation between their Title X and non-Title X activities. Declaration of Julie Rabinovitz ("Rabinovitz Decl."), Dkt. 38, ¶ 43; Declaration of Jenna Tosh ("Tosh Decl."), Dkt. 42, ¶ 39.[2] Other Title X providers will not risk jeopardizing the quality of care they provide to patients in order to comply with the Final Rule. The end result is decreased access to high-quality family planning and related preventative health services throughout the state. In rural areas, the harm will be even more pronounced, as women in these areas are at greater risk of losing their sole Title X clinic.

[2] All citations to declarations are to those filed in support of the State of California's Motion for Preliminary Injunction, *California v. Azar*, No. 3:19-cv-01184-EMC (N.D. Cal. Mar. 21, 2019), Dkt. 26.

A. The Final Rule Will Reduce the Number of Reproductive Health Care Providers in Rural Areas

A key area of dispute between the parties is how the removal of longstanding abortion counseling and referral requirements will affect the availability of reproductive health care services. Under the Title X regulations promulgated in 2000, abortion counseling and referrals had to be made available at the request of a patient. 42 C.F.R. § 59.5(a)(5) (2000). The counseling was required to be nondirective, comprising "neutral, factual information" about pregnancy options including prenatal care, foster care or adoption, and pregnancy termination, to help individuals make fully informed family planning decisions. *Id.* As has been the case since Title X's enactment, Title X funds may not be used to fund abortions. 42 U.S.C. § 300a- 6. The Final Rule, however, prohibits Title X centers not merely from using federal funds for abortion, but from saying or doing anything that would "promote" or "support" abortion, and also bars them from providing referrals for abortion even when the patient is the one who affirmatively requests it. 42 C.F.R. § 59.5(a)(5) (2019). Moreover, even presentation of options to pregnant clients is no longer required and these options can be presented only by physicians or others with graduate-level medical degrees. *Id.* § 59.14(b)(1).

HHS cited a set of unattributed comments submitted in support of the proposed changes to Title X which contend that "the 2000 regulations limit choice for patients, especially those who live in rural or remote areas, where faith-based and

local community organizations would be more likely to apply if the abortion counseling and referral requirement were lifted." 84 Fed. Reg. 7744. This is pure speculation, and contrary to fact.[3]

As Jenna Tosh, the President & CEO of Planned Parenthood California Central Coast and Chair of the Board of California Planned Parenthood Education Fund, explains, many Title X providers operating in rural communities already provide comprehensive reproductive health and family planning services, including contraception, prenatal counseling, and abortion counseling and referrals, *see* Tosh Decl. ¶¶ 11- 12, as well as labor and delivery services. Thousands of patients use these resources on a yearly basis. Many of these providers have already confirmed that they will be forced to withdraw from the Title X program and relinquish those federal funds because they are not willing to compromise the quality of care they

[3] HHS also cites to a survey of members of a faith-based organization, which reported that "82% of medical professionals 'said it was either "very" or "somewhat" likely that they personally would limit the scope of their practice of medicine if conscience rules were not in place. This was true of 81% of medical professionals who practice in rural areas and 86% who work full-time serving poor and medically-underserved populations . . . 91% agreed, "I would rather stop practicing medicine altogether than be forced to violate my conscience."'" 84 Fed. Reg. 7781 n.139. The district court's order highlights the many problems with relying on this survey—which did not even ask about Title X—to reach the conclusion that more providers would enter the Title X program under the Final Rule. *See California v. Azar*, No. 3:19-cv-01184-EMC, 2019 WL 1877392, at *34 (N.D. Cal. Apr. 26, 2019).

provide their patients. *See* Rabinovitz Decl. ¶ 40. The net consequence of this, of course, is that these providers will be forced to reduce how many women and adolescent girls they can serve and/or the range of services they can offer these women and adolescent girls.

As the district court noted, there is no reason to conclude that large numbers of qualified medical professionals are discouraged from seeking Title X funding because of their personal beliefs about abortion, particularly because HHS has already promulgated rules recognizing that Title X program requirements must be enforced consistently with federal conscience laws. *See Azar*, 2019 WL 1877392, at *34 (citing 76 Fed. Reg. 9968 (Feb. 23, 2011); 73 Fed. Reg. 78072 (Dec. 19, 2008)). HHS did not provide any evidence suggesting otherwise. On the contrary, CWLC has spoken with a clinic in a rural county in California, which reported that although some of its providers are exempt from counseling patients on abortion due to their personal beliefs, patients are able to receive comprehensive, nondirective pregnancy counseling from other providers whose personal beliefs do not preclude them from offering counseling on abortion, thereby striking an appropriate balance between freedom of conscience and public health.

B. The Final Rule Will Sharply Reduce Access to Essential Reproductive Care for Vulnerable Populations

Twelve counties in California—Humboldt, Imperial, Kern, Kings, Lake, Mendocino, Merced, Napa, Nevada, Placer, Stanislaus, and Sutter—that contain

nearly 3.1 million people, each have only a single Title X-funded clinic within their boundaries. Rabinovitz Decl. ¶ 28. And in seven rural counties in California, a Title X clinic is the only publicly funded clinic offering a full range of contraceptive methods. Declaration of Anna Rich ("Rich Decl."), Dkt. 39-8, Ex. H at 13. According to local providers contacted by CWLC, women in rural areas tend to be minorities, under 30, and are subsisting at 100 or 200 percent below the poverty line.

If those clinics withdraw from the Title X program, low-income and uninsured residents in those counties stand to lose critical resources for high-quality reproductive health care. And if they close, their patients would face unreasonable and unnecessary burdens to find other Title X providers. For example, if the single Title X-funded clinic in Humboldt County closes, its patients would have to drive up to 150 miles, or nearly three hours, to reach the next-closest Title X-funded clinic in Shasta County, assuming that clinic is able to remain open. Rabinovitz Decl. ¶ 28. Forcing low-income residents of rural communities to travel long distances for Title X-funded care—which may be the only the option they can afford—is more than merely inconvenient; it can also require patients to have to take unpaid time off work and can pose serious challenges if the patient has other children who need care. Many cannot afford these additional costs to access medically necessary and beneficial care.

HHS also claims that, as "patients may seek out health care providers that reflect their own religious beliefs or moral convictions, service delivery should be improved because opportunities for conflict may be limited and cultural competency of providers may be increased." 84 Fed. Reg. 7781. But there is no evidence that Title X is somehow artificially depressing the number of clinics serving rural areas. To the contrary, the existing Title X centers are, in many cases, the only high-quality reproductive health care available to low-income individuals in rural areas and elsewhere, and that has been the case since the program's inception. *See* Declaration of Kathryn Kost ("Kost Decl."), Dkt. 32, ¶¶ 7, 78.

Rather than create room for more "cultural[ly] competen[t]" providers as HHS contends, the Final Rule would diminish the quality of care provided, compromise Title X patients' ability to obtain timely, acceptable, and effective contraceptive methods, and increase individuals' risk of unintended pregnancy and undetected and untreated STIs. Kost Decl. ¶ 9; Declaration of Claire Brindis ("Brindis Decl."), Dkt. 27, ¶ 95. Indeed, the existing Title X network, while small, is already quite effective: A 2018 study of community health centers found that health centers which participate in Title X offer the highest quality family planning services, including offering a larger range of contraceptive methods dispensed on-site. Susan F. Wood et al., *Community Health Centers and Family Planning in an Era of Policy Uncertainty* 3, 7 (Mar. 2018), http://tinyurl.com/y6hen4h8. Those Title X-funded

sites were "less likely to report a lack of insurance coverage among patients, high out-of-pocket costs for patients, a lack of staff trained in IUD/implant procedures, the high cost of keeping contraceptives in stock, or inadequate insurance payments as major barriers to meeting the family planning and reproductive health needs of their patients." *Id.* at 16. Moreover, according to two clinics that CWLC spoke to in rural areas in California, health centers that receive Title X funds are able to offer patients not only enhanced reproductive health care, but also an assurance of confidentiality, which is very valuable for those attempting to maintain some privacy in their health care choices within a small community of individuals.

Even if new providers were to apply for Title X funds, there is no evidence that they would provide the same quality and range of services as current Title X providers of reproductive health services. Clinics that do not adhere to the Quality Family Planning Guidelines, authored by the HHS Office of Population Affairs and the Centers for Disease Control and Prevention, may not offer comprehensive contraception services, and staff at these facilities are often trained to delay women's decisions so that abortion becomes a less safe and accessible alternative. *See* Rabinovitz Decl. ¶ 46. It would be perverse indeed to divert Title X funds from high-quality clinics that have been serving vulnerable populations for decades to so-called "providers" that are not willing or able to provide many of the reproductive resources and information women in rural communities need.

This risk is not merely theoretical. Nearly two dozen pregnancy centers operating in California are located in rural communities. A 2010 investigation by the NARAL Pro-Choice California Foundation found that 93 percent of the counties in California—many of which are rural—have one or more of these pregnancy centers. NARAL Pro-Choice California Foundation, *Unmasking Fake Clinics: The Truth About Crisis Pregnancy Centers in California* 6 (2010), http://tinyurl.com/y2ovkfk9. These centers "increasingly target groups that are most underserved by the current health-care system" including "women living in rural locations." *Id.* Many of them are not licensed medical clinics, are not bound by the Health Insurance Portability and Accountability Act, do not in fact provide comprehensive women's reproductive health care, and offer information and "counseling" that is misleading at best and false at worst. *See* Amy G. Bryant & Jonas J. Swartz, *Why Crisis Pregnancy Centers are Legal but Unethical*, 20 AMA J. Ethics 269, 271 (March 2018), https://tinyurl.com/y4j7mla6. If these providers qualify for and receive Title-X funding, there is reason to believe their care would fall below the standard of patient-centered, quality medical care. *Id*. Even if they do not qualify for such funding, they are hardly adequate substitutes for the Title X facilities that are currently operating in rural areas that would be forced to close or withdraw from the Title X network.

Women in rural counties are in particular need of high-quality Title X-funded services that they stand to lose if the Final Rule goes into effect. For example, in California, rural counties have the highest teenage birth rates. Rabinovitz Decl. ¶ 26. But, despite being more likely to become pregnant, and, in many cases, lacking adequate financial support, these teenagers are less likely to receive family planning services because providers are few and far between and patients often must travel much farther than their urban counterparts to access such services. *Id.* In addition, there are at least ten counties in California where women lack access to the most effective forms of contraception—IUDs and implants. Tosh Decl. ¶ 49. Further, there is evidence that women in rural locations experience worse health outcomes than urban women and generally have less access to health care. *Id.*

Despite the pressing and substantial need for services, in many rural communities, there are very few options for quality reproductive health care. *See, e.g.*, American College of Obstetricians and Gynecologists, *Committee Opinion No. 586: Health Disparities in Rural Women* 2 (Feb. 2014, reaffirmed 2018), https://tinyurl.com/yyqfynk3 [hereinafter ACOG] (noting that "[o]bstetric and gynecological health services, including family planning, are limited in many nonmetropolitan areas"); *see also* Wood et al., *supra*, at 14 (reporting that existing community health care centers in rural areas cannot absorb a significant number of new patients). Only 46 percent of agencies providing publicly funded family

planning services reported being located in mostly rural locations. ACOG, *supra*, at 2. In the 2018 study of community health centers, 40 percent of rural and suburban centers reported that referral to a freestanding family planning clinic was not an option because there was no such clinic in their community. Wood et al., *supra*, at 14. There is also a nationwide shortage of physicians, especially in rural areas, *see* Bureau of Health Workforce, Health Resources and Services Administration, *Designated Health Professional Shortage Areas Statistics* 2 (June 30, 2019), https://tinyurl.com/y59fns4t, which would be amplified by the Final Rule's requirement that any pregnancy counseling be provided by physicians or others with graduate-level degrees. In short, the Final Rule would exacerbate the reproductive health concerns in these communities and make it far more difficult to address them in a safe and effective way.

C. The Experiences of Other States Belie HHS's Prediction About the Impact of the Final Rule

The experiences of low-income and vulnerable populations in other states offer a sobering warning of what California's rural communities could face if the Final Rule is implemented. In 2011 and 2017, Texas and Iowa—two states with large rural areas and populations that include individuals with more traditional or conservative religious beliefs—enacted policies to exclude health care providers that directly offer abortion or are affiliated with abortion providers from public funding, and state officials suggested, as HHS claims here, that new providers would replace

those excluded and that their residents' care would not be affected. *See* Kost Decl. ¶ 119. But instead, the result was widespread disruptions to the provider networks. *See id.*

In Texas, for example, the state's family planning program reported a nearly 15 percent decrease in enrollees statewide between 2011 and 2015. Texas Health and Human Services Commission, *Final Report of the Former Texas Women's Health Program: Fiscal Year 2015 Savings and Performance* 6 (Mar. 2017), https://tinyurl.com/y5xs723c. A Texas-based policy center found that, between 2011 and 2016, despite an increase in the number of providers, program enrollment declined by 26 percent and the proportion of women getting health care services in the program declined by nearly 40 percent. Center for Public Policy Priorities, *Comments on the Draft Healthy Texas Women Section 1115 Demonstration Waiver Application* 2 (June 12, 2017), https://tinyurl.com/yxdaae73. The state also reported a nearly 41 percent decline in claims and prescriptions for contraceptive methods from 2011 to 2015. Texas Health and Human Services Commission, *supra*, at 8.

Iowa experienced analogous dramatic declines in services covered and program enrollment. Its new state-administered program covered a total of only 970 family planning services from April through June of 2018, a 73 percent decline from the 3,637 services covered in April through June of 2017, the last three months of the previous family planning program, when abortion providers and affiliates were

still included. Tony Leys and Barbara Rodriguez, *State Family Planning Services Decline 73 Percent in Fiscal Year as $2.5M Goes Unspent*, Des Moines Reg., Oct. 18, 2018, https://tinyurl.com/y59bakcm. The number of patients enrolled in the program also fell by more than half. *Id.*

The harmful effects of limiting access to publicly funded reproductive health care reach beyond family planning. In Indiana, when funding cuts forced many clinics to close, rural areas experienced a large and rapid HIV outbreak. Rich Decl. Ex. G at 13 (comment letter submitted by the American College of Obstetricians and Gynecologists during the rulemaking period). Although the local Planned Parenthood clinic had provided HIV testing, free testing was unavailable after the clinic was forced to close.[4] Philip J. Peters et al., *HIV Infection Linked to Injection Use of Oxymorphone in Indiana, 2014-2015*, 375 New Eng. J. Med. 229, 230 (July 21, 2016), https://tinyurl.com/yycd4sfg.

The experiences of these states empirically contradict HHS's contention that equally qualified providers, including those that are faith-based, will step in to provide high-quality, neutral, and nondirective counseling and care in rural areas.

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[4] Although Planned Parenthood health centers represent just 13 percent of Title X-funded centers, they serve 41 percent of all Title X patients. Planned Parenthood Action Fund, *Title X: The Nation's Program for Affordable Birth Control and Reproductive Health Care*, https://tinyurl.com/y6as4bbj (last visited July 4, 2019). If the Final Rule takes effect, Planned Parenthood centers in California will no longer participate in Title X. Tosh Decl. ¶ 38.

Women and girls in rural communities across the country cannot afford the costs the Final Rule would impose.

CONCLUSION

HHS has not shown that the Final Rule will expand or enhance reproductive health care in rural areas. If the current Title X centers in rural communities must leave the program or close, there is no evidence that equivalent high-quality providers will fill the gaps in care. The Final Rule risks creating devastating, long-term, and irreversible repercussions on health care in rural communities in California and elsewhere.

Dated: July 8, 2019

s/ Theane Evangelis
Theane Evangelis
Counsel for Amicus Curiae

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the CM/ECF system on July 8, 2019. All participants in the case are registered CM/ECF users and will be served by the CM/ECF system, which constitutes service pursuant to Federal Rules of Appellate Procedure 25(c)(2) and Ninth Circuit Rule 25-5.

Dated: July 8, 2019

s/ Theane Evangelis
Theane Evangelis
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UNITED STATES COURT OF APPEALS
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