Nos. 18-15144; 18-15166; 18-15255

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

STATE OF CALIFORNIA, *et al.*,

Plaintiffs-Appellees,

v.

ALEX M. AZAR II in his official capacity as Acting Secretary of the U.S. Department of Health and Human Services, *et al.*,

Defendants-Appellants,

and

THE LITTLE SISTERS OF THE POOR JEANNE JUGAN RESIDENCE,

Intervenor-Defendant-Appellant,

and

MARCH FOR LIFE EDUCATION AND DEFENSE FUND,

Intervenor-Defendant-Appellant,

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

AMICUS BRIEF OF 17 CITIES, COUNTIES, AND LOCAL AGENCIES IN SUPPORT OF PLAINTIFFS-APPELLEES

OFFICE OF THE CITY ATTORNEY
CITY OF OAKLAND

BARBARA J. PARKER, City Attorney
MARIA BEE
ERIN BERNSTEIN
MALIA MCPHERSON
One Frank H. Ogawa Plaza, 6th Floor
Oakland, California 94612
Telephone: (510) 238-6392

Attorneys for Amicus Curiae
City of Oakland

OFFICE OF THE COUNTY COUNSEL
COUNTY OF SANTA CLARA

JAMES R. WILLIAMS, County Counsel
GRETA S. HANSEN
LAURA S. TRICE
ADRIANA L. BENEDICT
70 West Hedding Street
East Wing, Ninth Floor
San José, CA 95110-1770
Telephone: (408) 299-5900

Attorneys for Amicus Curiae
County of Santa Clara

Complete Listing of Amici Curiae

The County of Alameda, California
The City of Baltimore, Maryland
The City of Berkeley, California
Cook County, Illinois
The City of Los Angeles, California
The County of Los Angeles, California
The City of Minneapolis, Minnesota
The County of Monterey, California
The City of New York, New York
NYC Health + Hospitals
The City of Oakland, California
The City of Philadelphia, Pennsylvania
The City of Providence, Rhode Island
The City and County of San Francisco, California
The County of Santa Clara, California
The City of Seattle, Washington
The City of West Hollywood, California

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page

Cases

Statutes

Other Authorities

STATEMENT OF COMPLIANCE WITH RULE 29

This brief is submitted pursuant to Rule 29(a)(2) of the Federal Rules of Appellate Procedure with consent of all parties. *See* Dkt. No. 20 (letter giving consent to the filing of briefs by any prospective amicus curiae). No party's counsel authored this brief in whole or in part; no party or party's counsel contributed money to fund the preparation or submission of this brief; and no other person except amici curiae and their counsel contributed money to fund the preparation or submission of this brief.

INTERESTS OF AMICI

Amici are local government entities from across the United States that have both directly and indirectly benefited from the increased and more effective use of contraceptive methods made available by the Affordable Care Act ("ACA"). Amici—as well as other state and local governments around the country—will be significantly harmed if the contraceptive coverage requirement of the ACA is undermined. Accordingly, they oppose the federal government's unlawful attempts to reduce contraceptive coverage through the Interim Final Rules ("IFRs") and seek to ensure that families in their communities do not lose vital health coverage for contraception. Amici have a unique interest in the IFRs as local governments and providers of safety-net services, as described in more detail below.

Alameda County has a total population of approximately 1.6 million residents, with approximately 66,300 residents enrolled in Covered California. Alameda County is also home to 28 family planning centers. Alameda County is committed to providing, investing, and promoting essential healthcare services for its diverse communities. Alameda County values and strives to increase access to equity, fairness, and inclusive health services.

The City of Baltimore, with a population of more than 610,000, is the largest city in Maryland. The Baltimore City Health Department operates family planning and reproductive health services clinics that provide contraceptive services to residents regardless of their ability to pay.

The City of Berkeley is a diverse city of 121,200 people located in Alameda County. It is one of three cities in the State of California that is its own Local Public Health Jurisdiction. The Public Health Division has over 100 years of experience in providing safety-net services to individuals and families within the City of Berkeley. Through its clinic and school-based health centers, the Public Health Division provides comprehensive sexual and reproductive health care, including family planning services, teen-sensitive sexual and reproductive services, sexually transmitted infection screening, health education, and referrals to thousands of diverse community members each year. The City of Berkeley is committed to eliminating health inequities by providing services that address the social, educational, economic, and environmental factors that affect health.

Cook County is the largest county in the State of Illinois by population, with approximately 5 million residents. It owns and operates one of the largest public healthcare systems in the United States, the Cook County Health and Hospitals System (CCHHS), which provides a range of healthcare services regardless of a patient's ability to pay and serves approximately 300,000 unique patients annually through more than 1 million outpatient services and more than 20,000 admissions. The Cook County Department of Public Health, which is a part of CCHHS, serves 2.5 million residents in approximately 124 municipalities and serves the public health needs of its jurisdiction through effective and efficient disease prevention and health promotion programs, including family planning.

The City of Los Angeles is the second largest city in the United States with a population of approximately 4,000,000 people and home to numerous publicly funded family planning centers. A core mission of the City of Los Angeles is to provide for the health and safety of its residents, and access to contraception, like other reproductive healthcare services, is critical to advancing that mission.

Los Angeles County is home to over 10 million residents who rely on the County to provide essential health and social services. The County of Los Angeles is the second largest municipal health system in the nation. Through an integrated system of nineteen health centers and four hospitals, the County of Los Angeles annually cares for approximately 600,000 patients. The County of Los Angeles is the only public safety-net healthcare provider in Los Angeles County.

Minneapolis is the largest city in the State of Minnesota with a population of 414,000. The City of Minneapolis has had its own Board of Health since it was first incorporated in 1867. As part of its public health mission, the City of Minneapolis has a unique interest in assuring access to safe, affordable contraceptive services.

Monterey County, California is a large, geographically and demographically diverse county with a population of over 435,000. Monterey County owns and operates Natividad Medical Center ("Natividad"), a 172-bed acute care hospital that provides public safety-net healthcare to the residents of Monterey County. Through Natividad and the Monterey County Health Department, Monterey County provides contraceptive services to residents regardless of their ability to pay. Monterey County

also provides safety-net services—including comprehensive family planning services—as a provider for California's Family Planning, Access, Care, and Treatment ("Family PACT") Program.

The City of New York, New York is the nation's most populous city, with over 8.5 million residents. The City of New York's Department of Health and Mental Hygiene operates sexual health clinics offering contraceptive-related services, regardless of ability to pay, across the City of New York. NYC Health + Hospitals is a public authority that constitutes the nation's largest municipal healthcare system, providing care to well over a million New Yorkers annually, regardless of ability to pay, and offering women's health services at numerous patient-care sites in the City of New York.

Oakland, California is the largest city in Alameda County with a population of approximately 420,000 people. Oakland is home to numerous publicly funded family planning centers and has a unique interest in the IFRs informed by its role as a local government.

Philadelphia is the most populous city and county in Pennsylvania, with a population of more than 1.5 million. The Philadelphia Department of Public Health operates a network of safety-net health centers, providing primary healthcare services (including reproductive health care) to residents, and administers a host of other programs and services for infants, pregnant women, and new mothers.

The City of Providence has a population of nearly 180,000, is the capital of Rhode Island, and is the center of a metropolitan area including 1.6 million residents. Providence has a unique interest in the IFRs because of the vital role healthcare facilities in the City of Providence, including publicly funded family planning centers, play in the health of the population of the City of Providence, the State of Rhode Island, and the entire region.

San Francisco, California is the only combined city and county in the state. San Francisco's Department of Public Health ("SFDPH") protects and promotes the health of all San Franciscans, regardless of their ability to pay. Through the San Francisco Health Network, SFDPH provides the only complete healthcare system in the city. The San Francisco Health Network includes fourteen primary care clinics and the Zuckerberg San Francisco General Hospital and Trauma Center ("ZSFG"). The San Francisco Health Network is a safety-net provider that delivers comprehensive healthcare services to San Franciscans for free or at low-cost, including family planning, prenatal care, labor and delivery, maternal care, and pediatrics. ZSFG cares for approximately one in eight San Franciscans a year and delivers over one thousand babies each year.

Santa Clara County, California, is the most populous county in northern California, with approximately 1.9 million residents. It owns and operates the Santa Clara Valley Medical Center ("SCVMC"), a comprehensive public healthcare delivery system and the only public safety-net healthcare provider in Santa Clara County.

Through SCVMC and the Santa Clara County Public Health Department, the County provides contraceptive services to residents regardless of their ability to pay. The County also provides safety-net services—including comprehensive family planning services—as a provider for California's Family PACT Program. The Santa Clara County Board of Supervisors has recognized that the IFRs will significantly burden the County and threaten public health.[1]

Seattle is the largest city in the State of Washington, with a metropolitan area population of 3,733,580. Seattle is a partner in the Public Heath—Seattle & King County Public Health District. The Health District has established a Family Planning Program whose primary goal is to decrease the rate of unintended (unplanned) pregnancy and improve the reproductive and sexual health of all King County residents. The Family Planning Program provides clinical services to over 19,000 individuals a year, as well as community outreach, health education, pregnancy testing, and information and referral services.

The City of West Hollywood, California, population 40,000, provides a wide variety of social services to its residents and is vitally interested in the availability of contraceptive services to its residents.

---

[1] Resolution of the Board of Supervisors of the County of Santa Clara Supporting Access to Contraceptives (Dec. 5, 2017), *available at* https://sccgov.iqm2.com/Citizens/Detail_LegiFile.aspx?Frame=SplitView&MeetingID=8508&MediaPosition=5978.000&ID=89315&CssClass=.

INTRODUCTION

Family planning tools—including contraception—provide a wide range of benefits not only to individuals and families, but also to the government institutions charged with promoting and protecting public health. Contraception helps families avoid unplanned pregnancies, improves women's access to educational and economic opportunities, promotes maternal and infant health, and reduces overall public spending. For the state and local governments that bear responsibility for ensuring the health and well-being of their communities, family planning is at the heart of that charge.

When Congress passed the Affordable Care Act ("ACA"), it recognized the crucial role of broad contraceptive access and use both for individual self-determination and in promoting public healthcare goals more broadly. Accordingly, the ACA requires that most private health insurance plans cover without cost-sharing all 18 distinct contraceptive methods approved by the U.S. Food and Drug Administration ("FDA") for use by women, as well as any new methods identified by the FDA.[2] They must also cover all related services, including contraceptive

---

[2] U.S. Dep't of Labor, *FAQs About Affordable Care Act Implementation* (Part XXVI) (May 11, 2015), https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xxvi.pdf; *see also* Adam Sonfield, *Despite Leaving Key Questions Unanswered, New Contraceptive Coverage Exemptions Will Do Clear Harm*, Guttmacher Inst. (Oct. 17, 2017),

counseling, services needed to initiate and discontinue a contraceptive method, and follow-up care.[3]

These coverage requirements are not arbitrary. Rather, decades of research supports the conclusion that individuals use contraception more frequently and effectively when up-front financial and logistical barriers are removed. Some of the most effective and cost-effective forms of contraception are also those with the greatest upfront costs, which are more difficult to access without health coverage. Prior to the passage of the ACA, insurers could refuse to cover the most effective forms of contraception, decline to cover contraceptive-related medical appointments, or impose impractically large copayments. The IFRs allow a partial return to this regime by dramatically expanding the existing religious exemption and creating an entirely new moral exemption that allows employers with religious or moral objections to opt out of providing contraceptive coverage. 82 Fed. Reg. 47,792 (Oct. 13, 2017) (Religious Exemption); 82 Fed. Reg. 47,838 (Oct. 13, 2017) (Moral Exemption).

When women cannot access reliable and affordable contraception, the increased fiscal and public health costs of resulting unplanned pregnancies are often

---

https://www.guttmacher.org/article/2017/10/despite-leaving-key-questions-unanswered-new-contraceptive-coverage-exemptions-will.

[3] *Id.*

borne by state and local governments. One main goal of the ACA was to expand health coverage to individuals who otherwise might not be able to afford insurance at all; it is only logical that the costs of health care not covered by private insurers will be borne directly or indirectly by public healthcare and social service providers. These costs are real. If the IFRs are allowed to take effect, state and local governments throughout the nation will have to pick up the slack and provide contraceptive services more broadly. State and local governments will also bear the costs of providing critical services and medical care as women lose contraceptive coverage and unplanned pregnancies increase. As unplanned pregnancies take a financial toll on families, those families may slip out of private health coverage altogether and rely more heavily on safety-net care generally. Because of the widespread direct and indirect harms to local governments, Amici support affirmance of the trial court's ruling granting a nationwide injunction in this case.

ARGUMENT

I. THE IFRS BURDEN STATE AND LOCAL GOVERNMENT SAFETY-NET SERVICE PROVIDERS

The ACA's contraceptive coverage requirement ensures that a woman can choose a reliable contraception method without regard to upfront costs or other insurance considerations that might make a less effective method more affordable. Oral contraception (the "pill"), female sterilization, and intrauterine devices ("IUDs") are three of the four most commonly used methods of contraception (along with the

condom).[4] The pill, sterilization, and the IUD are also among the most highly effective forms of birth control.[5] While these highly effective methods are ultimately cost-effective, they entail high up-front costs. In the absence of the contraceptive coverage guarantee, many women would need to pay more than $1,000 to start using one of these methods—nearly one month's salary for a woman working full-time at the federal minimum wage of $7.25 an hour.[6] Even oral contraceptives, which are twice as effective as condoms in practice,[7] require a prescription and can cost up to $50 per month without insurance.

While some states have independently taken steps to make contraceptives more accessible, there are inherent limitations to piecemeal approaches. Prior to the passage of the ACA, only 28 states had laws requiring that health insurance plans include prescription birth control and ensure that contraception not be treated differently than other prescription medications.[8] But even those laws did not require

---

[4] *See* Megan L. Kavanaugh & Jenna Jerman, *Contraceptive Method Use in the United States: Trends and Characteristics Between 2008, 2012 and 2014*, 97 Contraception 14, 16 (2017).

[5] U.S. Food & Drug Admin., *Birth Control Guide* (last visited May 9, 2018), https://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM517406.pdf.

[6] Adam Sonfield, *What Is at Stake with the Federal Contraceptive Coverage Guarantee?*, 20 Guttmacher Pol'y Rev. 8, 9 (2017).

[7] *Birth Control Guide*, *supra* note 5.

[8] *Oral Contraceptive Pills*, Kaiser Family Found. (Aug. 17, 2017), https://www.kff.org/womens-health-policy/fact-sheet/oral-contraceptive-pills/; *see*

such coverage without cost-sharing, and they do not require coverage for individuals who are covered by self-insured health plans governed by the Employee Retirement Income Security Act ("ERISA").[9] Accordingly, the ACA has had profound effects on reducing contraceptive costs for women[10] and decreasing women's reliance on publicly funded contraceptive care.[11] Under the IFRs, significant numbers of insured

---

also Insurance Coverage of Contraceptives, Guttmacher Inst. (last visited May 10, 2018), https://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives (Twenty-nine states currently require insurers that cover prescription drugs to provide coverage of FDA-approved prescription contraceptive drugs and devices.).

[9] Laurie Sobel et al., *Private Insurance Coverage of Contraception*, Kaiser Family Found. (Dec. 6, 2016), http://kff.org/womens-health-policy/issue-brief/private-insurance-coverage-of-contraception/.

[10] *See, e.g.*, Nora V. Becker & Daniel Polsky, *Women Saw Large Decrease in Out-Of-Pocket Spending for Contraceptives After ACA Mandate Removed Cost Sharing*, 34 Health Aff. 1204 (2015); Adam Sonfield et al., *Impact of the Federal Contraceptive Coverage Guarantee on Out-of-Pocket Payments for Contraceptives: 2014 Update*, 91 Contraception 44 (2015).

[11] *See* Jennifer J. Frost et al., *Contraceptive Needs and Services, 2014 Update* (Sept. 2016), https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf ("Between 2013 and 2014, millions of Americans gained health insurance through provisions of the ACA—either as newly eligible Medicaid enrollees or by purchasing health insurance through the ACA's health insurance marketplaces. Among poor and low-income women in need of contraceptive services, the change in insurance status was dramatic. Over this one-year period, the number of women in need of publicly funded contraceptive care who had neither public nor private health insurance fell by nearly 20%, from 5.6 million to 4.5 million."); Kinsey Hasstedt, *Through ACA Implementation, Safety-Net Family Planning Providers Still Critical for Uninsured—and Insured—Clients* (Aug. 18, 2016), https://www.guttmacher.org/article/2016/08/through-aca-implementation-safety-net-family-planning-providers-still-critical (Small-scale investigation of 28 safety-net family planning centers found that proportion of family planning visits not covered by insurance went gone down after the ACA. "Most notably, the proportion of visits

women will lose access to comprehensive contraceptive coverage, and the opposite effect will occur. State and local governments will bear the costs of women losing health coverage of contraceptive care—either through the increased direct costs of providing subsidized contraception[12] or the broader costs of unplanned pregnancies.[13]

The IFRs' expanded exemptions to the contraceptive coverage requirement will decrease health coverage of effective contraception, forcing individuals to either pay for such coverage out-of-pocket or to seek contraceptive coverage from available state and local programs. Indeed, if the IFRs are not enjoined, employers offering certain health plans could drop contraceptive coverage with minimal or even no notice to employees and beneficiaries, leaving potentially millions of women without coverage for necessary contraceptive services or without any contraception at all.

A. The IFRs Will Decrease Effective And Consistent Use of Reliable Contraception And Increase Risk of Unplanned Pregnancies

As pre-ACA studies have repeatedly shown, health coverage is crucial for effective and continuous use of family planning methods. For example, a 2007 study

---

paid for by private insurance at the 28 sites rose from 14% in the last three quarters of 2013 to 22% in in the same period of 2015.").

[12] *See, e.g.*, *Welcome to Family PACT* (June 28, 2017), http://www.familypact.org/Home/home-page.

[13] *See, e.g.*, 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 Milbank Q. 667, 690-96 (2014).

showed that uninsured women "were 30% less likely to report using prescription contraceptive methods" than women with some form of insurance.[14] By extension, a post-ACA study based on claims data found that "women were less likely to stop using the pill once costs were removed in the wake of the federal contraceptive coverage guarantee."[15]

The loss of health coverage for contraceptives will likely increase the rate of unplanned pregnancies. Indeed, 95% of unintended pregnancies are attributable to the one-third of women who do not use contraceptive methods or who use them inconsistently.[16] When women suddenly lose health coverage for contraception, inconsistent use or discontinued use of contraception may follow.[17] Low-income women, women of color, and women aged 18-24 are at disproportionately high risk for unintended pregnancy.[18]

---

[14] Kelly R. Culwell & Joe Feinglass, *The Association of Health Insurance with Use of Prescription Contraceptives*, 39 Persp. on Sexual & Reprod. Health 226, 226-28 (2007).

[15] Sonfield, *supra* note 6, at 10 (citing Lydia E. Pace et al., *Early Impact of the Affordable Care Act on Oral Contraceptive Cost Sharing, Discontinuation, and Nonadherence*, 35 Health Aff. 1616 (2016)).

[16] *Id.* at 9.

[17] Pace et al., *supra* note 15 (study of U.S. women with employer-sponsored insurance found that higher copayments were associated with greater discontinuation of and non-adherence to generic pills than was the case with zero copayments).

[18] Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008–2011*, 374 New Eng. J. Med. 843, 845-49 (2016).

Unplanned pregnancies have direct health and financial repercussions for women, their families, and their communities. The negative health and socioeconomic outcomes associated with unplanned births are well-established.[19] Unplanned pregnancies are associated with delayed initiation of prenatal care and a decreased likelihood of breast-feeding.[20] Short spacing between pregnancies increases the risk of negative birth outcomes, namely, preterm birth and low-birth-weight babies.[21] Moreover, the ability to plan pregnancies allows women the time and financial ability to invest in their own education and careers and to participate more fully in the workforce, benefitting not only themselves and their families but also society as a whole.[22]

---

[19] Mary Tschann & Reni Soon, *Contraceptive Coverage and the Affordable Care Act*, 42 Obstetrics & Gynecology Clinics N. Am. 605, 606 (2015).

[20] *Id.* (citing Jessica D. Gipson et al., *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 Stud. in Family Planning 18 (2008)).

[21] Agustin Conde-Agudelo et al., *Birth Spacing and Risk of Adverse Perinatal Outcomes: A Meta-analysis*, 295 J. Am. Med. Ass'n 1809 (2006); *see also* Bao-Ping Zhu, *Effect of Interpregnancy Interval on Birth Outcomes: Findings from Three Recent US Studies*, 89 Int'l J. Gynecology & Obstetrics S25 (2005).

[22] Claudia Goldin & Lawrence F. Katz, *The Power of the Pill: Oral Contraceptives and Women's Career and Marriage Decisions*, 110 J. Pol. Econ. 730 (2002); *see also* Claudia Goldin & Lawrence F. Katz, *Career and Marriage in the Age of the Pill*, 90 Am. Econ. Rev. 461 (2000).

B. The IFRs Will Directly Financially Harm State And Local Governments

The IFRs run contrary to the ACA's goal of reducing financial and logistical barriers to effective and consistent contraceptive use. The unintended pregnancies that will result from the IFRs not only risk the health and well-being of women and their families, but will also result in substantial financial implications for public entities that provide safety-net care for women and families. On a national level, one study estimates that unplanned pregnancies and one year of infant medical care cost taxpayers $11 billion annually.[23]

As discussed above, the IFRs will result in a substantial number of women across the United States losing employer-sponsored contraceptive coverage—often with little or no notice from employers. And while the availability of public contraceptive coverage differs by state, it is without doubt that some portion of those women will qualify for state- or locally subsidized care either to fill the gap left by private insurers or to provide prenatal and infant health care. In fact, from 2006 to 2010, one in four women who obtained contraceptive services did so at a publicly funded center.[24] Research shows that the ACA's coverage expansions in 2014 led to a

---

[23] Emily Monea & Adam Thomas, *Unintended Pregnancy and Taxpayer Spending*, 43 Perspect. Sexual & Reprod. Health 88 (2011).

[24] *See* Jennifer J. Frost, *U.S. Women's Use of Sexual and Reproductive Health Services: Trends, Sources of Care and Factors Associated with Use, 1995-2010* (2013), at 16,

significant decrease in the proportion of U.S. women who were uninsured, which corresponded to a decreased proportion of women relying on publicly funded family planning services.[25] As the number of women without full health coverage for contraception rises, this trend will reverse and require state and local governments to once again fill the gaps in coverage.

Although requirements vary from state to state, local governments across the country are responsible for providing a wide range of healthcare services as part of the social safety-net.[26] In California, for example, all 58 counties are required to provide safety-net health services. Cal. Welf. & Inst. Code § 17000. Nationally, localities fund

---

https://www.guttmacher.org/sites/default/files/report_pdf/sources-of-care-2013.pdf.

[25] *See* Frost et al., *supra* note 11; Hasstedt, *supra* note 11.

[26] *See Counties' Role in Health Care Delivery and Financing*, Nat'l Ass'n of Cntys. (July 2007), at 3, http://http://www.naco.org/sites/default/files/documents/Counties'%20Role%20in%20Healthcare%20Delivery%20and%20Financing.pdf (In 23 states, counties are required to provide medical services to their low-income and chronically ill residents.); Eileen Salinsky, *Governmental Public Health: An Overview of State and Local Public Health Agencies*, Nat'l Health Pol'y F. (Aug. 18, 2010), at 9-10, https://www.nhpf.org/library/background-papers/BP77_GovPublicHealth_08-18-2010.pdf (Twenty-nine states have established a decentralized organizational model for public health in which local public health agencies are organizationally independent of the state agency and are primarily governed by local authorities. Of the 2,794 local health departments in the United States, most (60%) serve counties; some (18%) serve a city, town, or township; some (11%) serve a joint city/county jurisdiction; and some (9%) serve a multicounty region.).

or support safety-net health centers that provide free or reduced-fee services to clients, in addition to other types of local programs.[27] Family planning services offered at such centers or through other local programs may include contraception, pregnancy and sexually transmitted disease testing, and other services for maternal and child health.[28] In 2010, 82% of U.S. counties had at least one safety-net health center providing family planning services, and 72% of counties had at least one Title X-funded center.[29]

State and local governments, as safety-net providers, will inevitably bear a financial burden. For example, California's Family PACT Program offers comprehensive family planning services at no cost to families below 200% of the federal poverty level and no other source of family planning coverage.[30] As women with private health insurance lose contraceptive coverage, those who make less than 200% of the federal poverty level will likely opt into that program.

---

[27] *See Fact Sheet: Publicly Funded Family Planning Services in the United States*, Guttmacher Inst. (Sept. 2016), https://www.guttmacher.org/fact-sheet/publicly-funded-family-planning-services-united-states.

[28] *See generally* Salinsky, *supra* note 26; *Fact Sheet: Publicly Funded Family Planning Services in the United States*, *supra* note 27.

[29] *See Fact Sheet: Publicly Funded Family Planning Services in the United States*, *supra* note 27 (citing Special tabulations of data from Jennifer J. Frost et al., *Contraceptive Needs and Services 2010*, Guttmacher Inst. (July 2013)).

[30] *Welcome to Family Pact*, *supra* note 12.

Yet, the coverage of these services by Family PACT does not mean that California's local governments provide the care free of local cost. Although funding for Family PACT is provided by California and the federal government through the State's Medicaid program, the reimbursements paid to Family PACT providers do not cover the full cost of providing these services. Overall, as more employers opt out of contraceptive coverage, more low-income people will seek services through Family PACT or the other local government programs, at a direct cost to local governments. As the various local health systems already operate at a significant deficit because of uncompensated costs incurred in serving uninsured and under-insured patients, the IFRs will only exacerbate local fiscal problems.

Nor could cost increases be avoided by states and local governments opting out of contraceptive care. Rather, in the absence of more publicly funded family planning services, there will be more demand for public funding for medical costs related to pregnancy, delivery, and early childhood care.[31] In 2010, every $1.00 invested in publicly funded family planning services saved $7.09 in Medicaid expenditures that would otherwise have been needed to pay the medical costs of pregnancy, delivery, and early childhood care.[32] As safety-net healthcare funders and

---

[31] *See e.g.*, Frost et al., *supra* note 13.

[32] *Id.*

providers, local jurisdictions may have to fund many of the medical services associated with unintended pregnancies, which disproportionately affect young, low-income women.[33]

Finally, local governments are likely to be harmed by the decrease in tax revenues when women lose economic opportunities from unexpected pregnancies. For example, one recent study indicates that gender equity and participation of women in the economy promotes *overall* economic development in cities.[34] The study found that between 1980 and 2010, every 10% increase in female labor force participation rates in metropolitan areas was associated with an increase in real wages of nearly 5%.[35] Such growth is significant for state and local governments that rely heavily on their tax base to fund public services in their jurisdictions.

II. NATIONWIDE INJUNCTIVE RELIEF IS NECESSARY AND APPROPRIATE

Despite the widespread impact of the IFRs, none of the Amici—nor any other affected jurisdiction, entity, or individual—was afforded the opportunity to comment on the IFRs before they took effect. This failure of process violates the APA and

---

[33] Finer & Zolna, *supra* note 18, at 845-49.

[34] Amanda L. Weinstein, *Working women in the city and urban wage growth in the United States*, 57 J. Regional Sci. 591 (2015).

[35] *Id.*

renders the IFRs invalid, across the board and in all applications. Given the scope of this violation, the nationwide injunction issued by the district court was entirely appropriate. *See Califano v. Yamasaki*, 442 U.S. 682, 702 (1979). Numerous cases both within and outside this Circuit have upheld nationwide injunctions granted in the face of similar across-the-board violations.[36] Such injunctions are commonplace to prevent the implementation of categorically unlawful federal action,[37] and nationwide relief is the norm in cases, like this one, that raise facial challenges to federal rules under the Administrative Procedure Act ("APA"). *Paulsen*, 413 F.3d at 1008; *Nat'l Min. Ass'n*, 145 F.3d at 1409.

Moreover, absent a nationwide injunction, the IFRs would cause irreparable harm without geographic limitation. Women in every city, county, and state need

---

[36] *See, e.g.*, *Earth Island Inst. v. Ruthenbeck*, 490 F.3d 687, 699 (9th Cir. 2007), *aff'd in part, rev'd in part on other grounds sub nom. Summers v. Earth Island Inst.*, 555 U.S. 488 (2009); *Paulsen v. Daniels*, 413 F.3d 999, 1008 (9th Cir. 2005); *City of Chicago v. Sessions*, 888 F.3d 272, 290 (7th Cir. 2018); *Texas v. United States*, 809 F.3d 134, 187-88 (5th Cir. 2015), *aff'd*, 136 S. Ct. 2271 (2016); *Nat'l Mining Ass'n v. U.S. Army Corps of Eng'rs*, 145 F.3d 1399, 1408-10 (D.C. Cir. 1998); *Decker v. O'Donnell*, 661 F.2d 598, 617-18 (7th Cir. 1980).

[37] *See, e.g.*, *Regents of the Univ. of Cal. v. U.S. Dep't of Homeland Sec.*, No. 17-5211, 2018 WL 339144 (N.D. Cal. Jan. 9, 2018); *Alameda Health Sys. v. Ctrs. for Medicare & Medicaid Servs.*, 287 F. Supp. 3d 896, 919 (N.D. Cal. 2017); *Citizens for Better Forestry v. U.S. Dep't of Agric.*, 481 F. Supp. 2d 1059, 1100 (N.D. Cal. 2007); *Pennsylvania v. Trump*, 281 F. Supp. 3d 553 (E.D. Pa. 2017); *Karnoski v. Trump*, No. 17-1297, 2017 WL 6311305 (W.D. Wash. Dec. 11, 2017); *Doe 1 v. Trump*, No. 17-1597, 2017 WL 4873042 (D.D.C. Oct. 30, 2017); *Nw. Immigrants' Rights Project v. Sessions*, No. 17-716, 2017 WL 3189032 (W.D. Wash. Jul. 27, 2017).

access to contraceptive coverage, and virtually every city, county, and state will bear the burdens associated with reduced access to contraceptive coverage if the IFRs are allowed to stand. State and local governments throughout the nation provide safety-net services to women who lack adequate contraceptive coverage—in the form of subsidized contraceptive services and/or assistance related to unplanned pregnancies. If the IFRs are not enjoined on a nationwide basis, state and local governments across the country will be forced to expend scarce resources either to bring duplicative lawsuits or to step in and meet the needs of more women, children, and families.

Under these circumstances, the district court's decision to grant a nationwide injunction was necessary and correct—and certainly not an abuse of its broad equitable discretion. *See eBay Inc. v. MercExchange, L.L.C.*, 547 U.S. 388, 391 (2006); *Alaska Ctr. for Env't v. Browner*, 20 F.3d 981, 986 (9th Cir. 1994). Indeed, the Seventh Circuit recently considered and rejected the federal government's arguments against nationwide relief, upholding a nationwide injunction obtained by the City of Chicago to prevent implementation of certain federal grant conditions. *City of Chicago*, 888 F.3d at 287-93. After carefully analyzing the arguments for and against nationwide injunctions, the Seventh Circuit concluded that nationwide injunctions "play an important and proper role" in cases involving "issues of widespread national impact" and rejected the federal government's arguments as "inconsistent with precedent and inadvisable." *Id.* at 288, 290. Under the Seventh Circuit's analysis, a district court may properly apply an injunction nationwide where: (1) the case raises a facial challenge to

a nationwide policy and "presents purely a narrow issue of law . . . [that] is not fact-dependent and will not vary from one locality to another," *id.* at 290; (2) a nationwide injunction would avoid widespread irreparable harm, including harm to local governments throughout the country, *id.* at 288; and (3) absent a nationwide injunction, actions would need to be brought "swiftly" and "simultaneous[ly] in numerous jurisdictions," *id.* at 292. Each of these circumstances is present here.

A. The Case Raises A Facial Challenge And Narrow Issue of Law

The district court's injunction is predicated on an APA claim that presents a narrow legal question: whether the federal government was required to provide notice and an opportunity to comment on the IFRs before giving them effect. This narrow question of law does not depend at all on varied factual circumstances, and Defendants have not argued it does. Whether Defendants had statutory authority or good cause under the APA to forgo advance notice and comment does not vary across jurisdictions. Nor does the question of whether Defendants' action was harmless error. The legality of Defendants' action rises or falls without regard to the particular circumstances of different jurisdictions. This is consistent with the "ordinary result" when a federal rule is found invalid under the APA: the rule is enjoined or vacated in its entirety, on a nationwide basis and not merely as to the plaintiffs bringing the challenge. *Nat'l Min. Ass'n*, 145 F.3d at 1409; *see also Paulsen*, 413 F.3d at 1008.

B. The Harm From The IFRs Is Widespread And Nationwide

The balance of the equities also supports nationwide relief in light of the widespread procedural and substantive harms resulting from the IFRs. As the district court explained, the procedural injury from Defendants' action was universal: "*no* member of the public was permitted to participate in the rulemaking process via advance notice and comment." *California v. Health & Human Servs.* ("Preliminary Injunction Order"), 281 F. Supp. 3d 806, 832 (N.D. Cal. 2017) (emphasis in original). Whatever their views on the IFRs, neither local jurisdictions like Amici, nor any other entity or individual, had an opportunity to comment on the IFRs until *after* they went into effect.[38] This procedural injury constitutes irreparable harm that is indisputably nationwide in scope.

---

[38] Local governments and agencies frequently comment on proposed rules that will affect them, and local entities, including some Amici and related agencies, commented on the IFRs *after* they took effect, when the federal government provided a belated opportunity for notice and comment. *See*., *e.g.*, Letter from James R. Williams et al., Office of the Cnty. Counsel, Cnty. of Santa Clara, to Ctrs. for Medicare & Medicaid Servs. ("CMS") (Dec. 5, 2017) (on file at https://www.regulations.gov/contentStreamer?documentId=CMS-2014-0115-58259&attachmentNumber=1&contentType=pdf); Letter from Mary T. Bassett, Comm'r, New York City Dep't of Health & Mental Hygiene & Steven Banks, Comm'r, New York City Dep't of Social Services, to CMS (Dec. 5, 2017) (on file at https://www.regulations.gov/contentStreamer?documentId=CMS-2014-0115-56218&attachmentNumber=1&contentType=pdf); Letter from Mila Kofman, Exec. Dir., DC Health Benefit Exch. Auth., to CMS (Dec. 5, 2017) (on file at https://www.regulations.gov/contentStreamer?documentId=CMS-2014-0115-58123&attachmentNumber=1&contentType=pdf).

The irreparable procedural harm is compounded by irreparable substantive harms with a nationwide impact—to Amici and other local governments, along with women, their families, their communities, and the states they live in. As described above, local governments across the country will bear significant financial burdens as a result of the IFRs. Local governments provide a wide range of safety-net healthcare services to their residents, including family planning and contraceptive services. Counties throughout the nation provide medical services to low-income individuals, and thousands of public health agencies operate at the local level. *See supra* at 2-10, 17-20. As more employers opt out of contraceptive coverage under the IFRs, more women will seek these locally subsidized services, including both low- and no-cost contraceptive services and a wide range of services and assistance associated with unplanned pregnancies. *See supra* at 17-20. Local governments often bear all or part of the costs of providing these services and will suffer adverse fiscal impacts stemming from increased demand. *See id.* At the same time, local governments nationwide are likely to face decreased tax revenues as more women miss out on economic opportunities due to unplanned pregnancies. *See supra* at 20. Given the role local governments play nationally in providing safety-net services, these harms will be widespread and nationwide in scope. A nationwide preliminary injunction is thus required to provide "complete relief" for both the procedural and substantive harms resulting from the IFRs, *see Bresgal v. Brock*, 843 F.2d 1163, 1170-71 (9th Cir. 1987),

and the district court appropriately exercised its broad equitable power to ensure that the IFRs are not afforded the force and effect of law.

C. The Public Interest Supports Nationwide Relief

Finally, in light of the immediate, nationwide impact of the IFRs, this case "does not present the situation in which the courts will benefit from allowing the issue to percolate through additional courts and wind its way through the system in multiple independent court actions." *City of Chicago*, 888 F.3d at 291. In the absence of a nationwide injunction, duplicative actions would have to be brought swiftly in numerous jurisdictions to prevent irreparable harm. The IFRs took effect on October 6, 2017, one week prior to formal publication in the Federal Register, and they allow as little as thirty-days' notice for revocation of contraceptive coverage by an eligible employer. 82 Fed. Reg. 47,813 (Oct. 13, 2017) (Religious Exemption); 82 Fed. Reg. 47,854 (Oct. 13, 2017) (Moral Exemption). Once implemented, the effects of the IFRs are not easily undone due to factors such as the time required for group health plans and health insurance issuers to take coverage "changes into account in establishing their premiums, and in making other changes to the designs of plan or policy benefits," 75 Fed. Reg. 41,730 (July 19, 2010); the cyclical start dates for health insurance plan years, *see* 76 Fed. Reg. 46,624 (Aug. 3, 2010); and lag times between open enrollment periods, *see* 42 U.S.C. § 18031(c)(6). Meanwhile, states and local governments throughout the nation would be footing the bill for subsidized contraceptive services or assistance related to unplanned pregnancies, and taking a hit

to their tax revenues due to lost productivity associated with unplanned pregnancies. Because the IFRs were designed to "go into effect quickly, and their impact cannot be reversed at the end of a lawsuit," the irreparable harms to local governments can only be prevented, and the interests of local governments "can only be protected[,] if a court concludes the policy is illegal and fully enjoins it."[39]

Under these facts, "[t]he public interest would be ill-served here by requiring simultaneous litigation of this narrow question of law in countless jurisdictions." *City of Chicago*, 888 F.3d at 292. Where lawsuits could be filed, the duplicative litigation would consume judicial resources unnecessarily, and in many jurisdictions, no government entity or other person harmed by the IFRs would "have the means to pursue . . . litigation" at all. *Id.* at 291. Local governments picking up the tab for employers who no longer provide cost-free contraceptive coverage should not be forced to divert already constrained fiscal resources from service provision to duplicative litigation. *See id.*

In any event, to the extent "percolation" is beneficial, the issues in this case already *have* percolated through multiple courts. The nationwide injunction entered by the Eastern District of Pennsylvania in *Pennsylvania*, 281 F. Supp. 3d 553, certainly did not stop the district court in this case from considering the same issue. Taxpayer

---

[39] Spencer E. Amdur & David Hausman, *Nationwide Injunctions and Nationwide Harm*, 131 Harv. L. Rev. F. 49, 51 (2017).

dollars should not have to be expended in every single jurisdiction where a preliminary injunction is necessary to avoid irreparable harm.

Here, as in *City of Chicago*, "the balance of equities and the nature of the claims require broader relief." 888 F.3d at 289. The nationwide preliminary injunction was not an abuse of the district court's broad equitable discretion and should not be disturbed on appeal.

CONCLUSION

For the foregoing reasons, the district court's judgment should be affirmed, and the nationwide preliminary injunction should remain intact.

Dated: May 29, 2018

Respectfully submitted:

CITY OF OAKLAND
Barbara J. Parker, City Attorney

By: /s/ Erin Bernstein
Erin Bernstein,
Supervising Deputy City Attorney

Maria Bee
Malia McPherson
One Frank H. Ogawa Plaza, 6th Floor
Oakland, California 94612
(510) 238-6392

Attorneys for the City of Oakland, California

COUNTY OF SANTA CLARA
James R. Williams, County Counsel

By: /s/ Adriana L. Benedict
Adriana L. Benedict,
Deputy County Counsel

Greta S. Hansen
Laura S. Trice
Office of the County Counsel
70 W. Hedding Street
East Wing, 9th Floor
San José, CA 95110
(408) 299-5900

Attorneys for the County of Santa Clara, California

[Additional Counsel for Amici Curiae Listed Below]

Additional Counsel for Amici Curiae

Donna R. Ziegler
County Counsel, County of Alameda
1221 Oak Street, Suite 450
Oakland, CA 94612
Attorney for the County of Alameda, California

Andre M. Davis
City Solicitor, City of Baltimore
100 N. Holliday Street, Suite 101
Baltimore, MD 21202
Attorney for the Mayor and City Council of Baltimore, Maryland

Farimah Brown
City Attorney, City of Berkeley
2180 Milvia Street, 4th Floor
Berkeley, CA 94074
Attorney for the City of Berkeley, California

Kimberly M. Foxx
State's Attorney for Cook County
69 W. Washington, 32nd Floor
Chicago, IL 60602
Attorney for Cook County, Illinois

Michael N. Feuer
City Attorney of the City of Los Angeles
200 N. Main Street, 800 CHE
Los Angeles, CA 90012
Attorney for the City of Los Angeles, California

Mary Wickham
County Counsel, County of Los Angeles
500 West Temple Street, 6th Floor
Los Angeles, CA 90012
Attorney for the County of Los Angeles, California

Susan L. Segal
Minneapolis City Attorney
350 S. 5th Street, Rm. 210
Minneapolis, MN 55415
Attorney for City of Minneapolis, Minnesota

Charles J. McKee
County Counsel, County of Monterey
William Litt, Deputy County Counsel
Office of the County Counsel
168 West Alisal St., 3rd Fl.
Salinas, CA 93901
Attorneys for County of Monterey, California

Zachary W. Carter
Corporation Counsel, City of New York
100 Church St.
New York, NY 10007
Attorney for the City of New York, New York and NYC Health + Hospitals

Marcel S. Pratt
City Solicitor, City of Philadelphia Law Department
One Parkway Building
1515 Arch Street
Philadelphia, PA 19102
Attorney for the City of Philadelphia, Pennsylvania

Jeffrey Dana
City Solicitor, City of Providence
444 Westminster Street, Suite 220
Providence, RI 02903
Attorney for the City of Providence, Rhode Island

Dennis J. Herrera
City Attorney, City and County of San Francisco
City Hall Room 234
One Dr. Carlton B. Goodlett Pl.
San Francisco, CA 94102
Attorney for the City and County of San Francisco, California

Peter S. Holmes,
Seattle City Attorney
701 Fifth Avenue, Suite 2050
Seattle, WA 98104-7097
Attorney for City of Seattle, Washington

Michael Jenkins
City Attorney, City of West Hollywood
Best Best & Krieger
1230 Rosecrans Avenue, Ste. 110
Manhattan Beach, CA 90266
Attorney for the City of West Hollywood, California

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit set forth in Federal Rules of Appellate Procedure 29(a)(5) because it contains 6,462 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Microsoft Word 2016 in Garamond 14-point font, a proportionally spaced typeface.

/s/ Adriana L. Benedict
ADRIANA L. BENEDICT

CERTIFICATE OF SERVICE

I hereby certify that on May 29, 2018, 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 appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

/s/ Adriana L. Benedict
ADRIANA L. BENEDICT

1784758