No. 18-35920

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PLANNED PARENTHOOD OF GREATER WASHINGTON AND NORTHERN IDAHO; PLANNED PARENTHOOD OF THE GREAT NORTHWEST AND THE HAWAIIAN ISLANDS; PLANNED PARENTHOOD OF THE HEARTLAND,

Plaintiffs-Appellants,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ALEX AZAR II, *in his official capacity as Secretary, U.S. Department of Health and Human Services*; VALERIE HUBER, *in her official capacity as the Senior Policy Advisor for the Office of the Assistant Secretary for Health*,

Defendants-Appellees.

On Appeal from the United States District Court
for the Eastern District of Washington (No. 18-cv-207)
Hon. Thomas O. Rice

BRIEF FOR THE COMMONWEALTHS OF PENNSYLVANIA, MASSACHUSETTS, AND VIRGINIA, AND THE STATES OF CALIFORNIA, CONNECTICUT, DELAWARE, HAWAI'I, ILLINOIS, IOWA, MARYLAND, MICHIGAN, MINNESOTA, NEVADA, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, AND WASHINGTON, AND THE DISTRICT OF COLUMBIA, AS AMICI CURIAE IN SUPPORT OF PLAINTIFFS-APPELLANTS

JOSH SHAPIRO
Attorney General of Pennsylvania

MICHAEL J. FISCHER
Chief Deputy Attorney General
AMBER SIZEMORE
Deputy Attorney General

Office of Attorney General
1600 Arch Street, Suite 300
Philadelphia, PA 19103
(215) 560-2171
mfischer@attorneygeneral.gov

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INTEREST OF AMICI STATES

The Commonwealths of Pennsylvania, Massachusetts, and Virginia, and the States of California, Connecticut, Delaware, Hawai‘i, Illinois, Iowa, Maryland, Michigan, Minnesota, Nevada, New Jersey, New York, North Carolina, Oregon, Rhode Island, Vermont, and Washington, and the District of Columbia (the "States") as amici curiae have a fundamental interest in promoting their residents' health and well-being. The federal Teenage Pregnancy Prevention Program ("TPP Program") provides vital funding for state, local, and community programs that have been shown to reduce rates of teenage pregnancy. It also serves to incubate new and innovative programs that, if proven effective in addressing teenage pregnancy, can be replicated elsewhere on a broader scale. The TPP Program is an indispensable component of State efforts to reduce the physical and medical risks of teenage pregnancy as well as its associated emotional, social, and financial costs.[1]

[1] Ctr. for Disease Control (CDC), *Vital Signs: Preventing Pregnancies in Younger Teens* (Apr. 2014), https://www.cdc.gov/vitalsigns/young-teen-pregnancy/index.html; Ctr. for Disease Control, *About Teen Pregnancy in the United States* (May 2017), https://www.cdc.gov/teenpregnancy/about/index.htm; Office of Adolescent Health (OAH) of the U.S. Dep't of Health & Human Servs. (HHS), *Negative Impacts of Teen Childbearing* (Nov. 2016), https://www.hhs.gov/ash/oah/adolescent-development/reproductive-health-and-teen-pregnancy/teen-pregnancy-and-childbearing/teen-childbearing/index. html.

Teenage parenthood has been shown to have an adverse impact on educational opportunities and economic security.[2] Children born to teenagers are at increased risk of poor educational, behavioral, and health outcomes.[3] The States have a compelling interest in preventing teenage pregnancy to protect the well-being and economic security of their teenage residents and their children and families. In addition, teenage births cost taxpayers between $9.4 billion and $28 billion a year through public assistance payments, lost revenue, and greater expenditures for public health care, foster care, and criminal justice services.[4] Preventing teenage pregnancy is estimated to have saved U.S. taxpayers $4.4 billion in 2015 alone.[5] The States have a strong interest in protecting their taxpayers from these associated costs.

The TPP Program has played a critical role in State efforts to reduce teen pregnancy because it was designed by Congress to promote medically accurate, evidence-based programs that have been proven effective through rigorous evaluation. Unlike other government funding programs—including other programs

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[2] *Vital Signs*, *supra* note 1.

[3] *Negative Impacts*, *supra* note 1.

[4] *Negative Impacts*, *supra* note 1; Nat'l Conference of State Legislatures, *Teen Pregnancy Prevention* (Oct. 11, 2018), http://www.ncsl.org/research/health/teen-pregnancy-prevention.aspx#5.

[5] *About Teen Pregnancy*, *supra* note 1.

specifically targeted toward teen pregnancy—the TPP Program does not require adherence to any particular ideology or methodology. Rather, the emphasis is on identifying what works—and on replicating programs that work, while also fostering the development and testing of new programs.

Congress expressly directed that all TPP Program grant funds support programs that are "medically accurate and age appropriate." *See* Consolidated Appropriations Act, 2018, Pub. L. No. 115-141, 132 Stat. 348, 766 (2018) ("2018 Appropriations Act"). Consistent with these goals, Congress chose to direct the largest portion of grant funding under the TPP Program to replicate programs "that have been proven effective through rigorous evaluation to reduce teenage pregnancy, behavioral risk factors underlying teenage pregnancy, or other associated risk factors" ("Tier 1 Grants"). *Id*. Even the additional TPP Program funds Congress designated for "research and demonstration" must still be "medically accurate and age appropriate" and are intended to "develop, replicate, refine, and test additional models and innovative strategies for preventing teenage pregnancy." ("Tier 2 Grants"). *Id*.

The 2018 Funding Opportunity Announcements ("FOAs") threaten to frustrate the design of the TPP Program and undermine the States' efforts to reduce

teen pregnancy.[6] The FOAs would shift the focus of the grant process to rewarding programs that promote a particular "abstinence-only" ideology, rather than following Congress's mandate to fund programs that are medically accurate and have been proven to work through rigorous evaluation. If the 2018 FOAs are allowed to stand, federal funds will be directed to less-effective or medically inaccurate programs, while others that have been proven to work will languish. As a result, more teens will be at risk of becoming pregnant, imposing significant additional costs on the States and their residents. For these reasons, the district court should be reversed and directed to enter summary judgment in favor of Plaintiffs.

[6] U.S. Dep't of Health & Human Servs., *Phase I Replicating Programs (Tier 1) Effective in the Promotion of Healthy Adolescence and the Reduction of Teenage Pregnancy and Associated Risk Behaviors* (Apr. 20, 2018) ("2018 Tier 1 FOA"); *U.S. Dep't of Health & Human Servs., Phase I New and Innovative Strategies (Tier 2) to Prevent Teenage Pregnancy and Promote Healthy Adolescence* (Apr. 20, 2018) ("2018 Tier 2 FOA").

ARGUMENT

I. The States Have A Strong Interest In Ensuring That TPP Program Funds Are Used To Support Medically Accurate, Evidence-Based Programs Proven To Reduce Teen Pregnancy.

A. Congress Designed the TPP Program to Promote Programs That Have Been Proven Effective Through Rigorous Evaluation.

Since its creation in 2009, the TPP Program has provided nearly $1 billion[7] for medically accurate, evidence-based teenage pregnancy prevention, awarding grants to 186 state, local, and community programs.[8] Those programs reached half a million teens from FY2010–FY2014, and are anticipated to reach 1.2 million more from FY2015–FY2019, with a focus on high-need communities and vulnerable youth, including those of color, in foster care, or in rural areas.[9]

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[7] From 2010 to 2018, the TPP Program received appropriations totaling $923,000,000. *See* Cong. Research Serv., *Teenage Pregnancy Prevention: Statistics and Programs* (Jan. 15, 2016) at CRS-23-24; Consol. Appropriations Act, 2017, Pub. L. No. 115-31, 131 Stat 135; Consol. Appropriations Act, 2018, Pub. L. No. 115-141, 132 Stat 348 ("2018 Appropriations Act").

[8] There were 102 grantees for the first round of five-year funding cycles in 2010 and 84 grantees for the second round in 2015. *See* Off. of Adolescent Health of the U.S. Dep't of Health & Human Servs., *About the Teen Pregnancy Prevention (TPP) Program* (Feb. 2017), https://www.hhs.gov/ash/oah/grant-programs/teen-pregnancy-prevention-program-tpp/about/index.html.

[9] Off. of Adolescent Health of the U.S. Dep't of Health & Human Servs., *Teen Pregnancy Prevention Program By the Numbers*, https://www.hhs.gov/ash/oah/sites/default/files/tpp-cohort-1/tpp-bythenumbers-infographic.pdf; Off. of Adolescent Health of the U.S. Dep't of Health & Human Servs., *Teen Pregnancy Prevention Program Teens Reached*; https://www.hhs.gov/ash/oah/sites/default/files/tpp-cohort-1/tpp-teensreached-infographic.pdf; and Off. of Adolescent Health of the U.S. Dep't of Health & Human Servs., *Performance Measures Snapshot, The Teen Pregnancy Prevention*

In creating the TPP Program and appropriating its annual funding, Congress has consistently emphasized the need to base awards on evidence-based criteria, not ideology. To this end, Congress has mandated that TPP funding be used only to support programs that are "medically accurate." 2018 Appropriations Act, 132 Stat. at 733. In order to ensure that programs are effective while also encouraging innovation, Congress has mandated that TPP grant funding be administered through two distinct but interrelated grant award "tiers." Tier 1 funds are to be spent "replicating programs that have been proven effective through rigorous evaluation to reduce teenage pregnancy, behavioral risk factors underlying teenage pregnancy, or other associated risk factors." *Id.* Tier 2 funds, on the other hand, are to support grants that through "research and demonstration" will "develop, replicate, refine, and test additional models and innovative strategies for preventing teenage pregnancy."[10]

In devising this structure, Congress sought to ensure that Tier 1 funds are awarded exclusively to programs that have already been validated through rigorous

Program: Performance in Fiscal Year 2017 (Year 2) (Oct. 2017), https://www.hhs.gov/ash/oah/sites/default/files/tpp-performance-measures-year-2-brief.pdf.

[10] The appropriations acts governing the TPP Program have included virtually identical language from 2009 to the present. *Compare* Consol. Appropriations Act, 2010, Pub. L. No. 11-117, 123 Stat 3034, *with* Consol. Appropriations Act, 2018, Pub. L. No. 115-141, 132 Stat 348.

evaluation using evidence-based criteria. Tier 2 funds are to be used to support new and innovative programs that, if found to be effective, may eventually become eligible for Tier 1 funding. The result is that the majority of TPP funding is spent on programs that have proven effective, while some funding promotes the development of new ideas and adds to the body of evidence by which pregnancy prevention programs can be evaluated and improved. In part due to its innovative structure, the TPP Program has been recognized as a successful model of self-sustainable, evidence-based policy making.[11] But the TPP model only works if both programs function as intended. Altering the criteria for either tier threatens the thoughtful, deliberate balance achieved through the existing structure.

B. The TPP Program Helps the States Address the Significant Costs Associated with Teen Pregnancy.

The States utilize the TPP Program to identify and support effective, evidence-based programs to reduce teenage pregnancy among their residents and address the wide range of individual and public costs associated with teenage pregnancy. As a result, the States will bear the costs associated with reduced access to effective teenage pregnancy prevention programs.

[11] Comm'n on Evidence-Based Policy Making, *The Promise of Evidence-Based Policymaking* (Sept. 2017), https://www.cep.gov/report/cep-final-report.pdf.

1. Teenage pregnancies negatively impact the health and well-being of teenage parents and their children.

During 2017, there were 194,284 teenage births nationwide:[12] 5,899 in Pennsylvania,[13] and 18,935 in California.[14] Although teenage birth rates have generally declined in the United States since the creation of the TPP Program,[15] teenage pregnancies continue to carry serious physical and medical risks, as well as emotional, social, and financial costs, for teenage mothers and fathers, and their children.

The adverse consequences of becoming a teenage mother are well-documented.[16] Approximately half of teenage mothers do not finish high school, and teenage mothers and their families are more likely to live in poverty and depend on public assistance.[17] In Pennsylvania, 1,375 high school students cited child care issues as their reason for dropping out of school from 2011 to 2017, with

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[12] Ctr. for Disease Control, *Vital Statistics Rapid Release: Births: Provisional Data for 2017*, https://www.cdc.gov/nchs/data/vsrr/report004.pdf.

[13] Power to Decide (The Campaign to Prevent Unplanned Pregnancy), *Pennsylvania Data*, https://powertodecide.org/what-we-do/information/national-state-data/pennsylvania.

[14] Power to Decide (The Campaign to Prevent Unplanned Pregnancy), *California Data*, https://powertodecide.org/what-we-do/information/national-state-data/california.

[15] *Provisional Data for 2017*, *supra* note 12.

[16] *Vital Signs*, *supra* note 1.

[17] *Teen Pregnancy Prevention*, *supra* note 9.

the numbers highest in years in which the teenage birth rate was also the highest.[18] Teenage fathers also experience reduced educational opportunities and decreased earning potential.[19]

Children born to teenagers are also at increased risk of poor health, educational, and behavioral outcomes.[20] In Pennsylvania, teenage mothers are less likely to receive early and adequate prenatal care and are more likely to give birth before reaching full term.[21] Nationwide, children born to teenage mothers are at higher risk of low or very low birth weight and infant mortality.[22] They often have lower school achievement, including decreased readiness measures; they are 50 percent more likely to repeat a grade; and they are more likely to drop out of school.[23] They also enter the child welfare and correctional systems more

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[18] Pa. Dep't of Educ., *Dropouts by Public School 2011-2012, 2012-2013, 2013-2014, 2014-2015, and 2016-2017*, http://www.education.pa.gov/Data-and-Statistics/Pages/Dropouts.aspx.

[19] Teen Pregnancy Prevention, *supra* note 9.

[20] *Negative Impacts supra* note 1; and *Teen Pregnancy Prevention*, *supra* note *9.*

[21] Pa. Dep't of Health, *Pennsylvania Healthy People*, "Maternal, Infant, and Child Health," Objectives MICH-9.1, 9.4, and 10.2 (Dec. 2018), https://www.health.pa.gov/topics/HealthStatistics/HealthyPeople/Documents/current/state/maternal-infant-and-child-health.aspx.

[22] Ctr. for Disease Control, *Births: Final Data for 2016*, Table 23 (Jan. 31, 2018), https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_01.pdf; *see also Pennsylvania Healthy People*, Objectives 8.1 and 8.2, *supra* note 21.

[23] *Teen Pregnancy Prevention*, *supra* note 9 .

frequently, and many become teenage parents themselves.[24] And ethnic and racial minorities are disproportionately impacted.[25] For instance, in California, despite declining birth rates, ethnical and racial disparities persist, with Hispanic females accounting for 75% of teen births.[26] Accordingly, preventing teenage pregnancy through efforts such as those funded by the TPP Program is essential to promote the health and well-being of the States' residents.

Preventing teenage pregnancies also protects the States' taxpayers. Teenage pregnancies nationwide cost taxpayers between $4.4 billion and $9.4 billion a year through public assistance payments, lost revenue, and greater expenditures for public health care, foster care, and criminal justice services.[27] The cost to Pennsylvania for providing medical and economic support during pregnancy and

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[24] *Negative Impacts supra* note 1; and *Teen Pregnancy Prevention*, *supra* note 9.

[25] Teresa Wiltz, *Racial and Ethnic Disparities Persist in Teen Pregnancy Rates*, Pew Charitable Trusts (Mar. 3, 2015), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/3/03/racial-and-ethnic-disparities-persist-in-teen-pregnancy-rates.

[26] Cal. Dep't of Public Health, *Adolescent Births in Cal. 2000–2016* (Aug. 2018), https://www.cdph.ca.gov/Programs/CFH/DMCAH/CDPH%20Document%20Library/Data/Adolescent/Adolescent-Birth-Rates-2016.pdf.

[27] *Negative Impacts supra* note 1; and *Teen Pregnancy Prevention*, *supra* note 9.

the first year of infancies averaged $19,000 per teen birth in 2015.[28] In fact, Pennsylvania is estimated to have saved $145 million in 2015 alone due to the declining teenage birth rate.[29] But Pennsylvania still spends an additional $68 million per year on costs associated with teenage pregnancies, which could be further reduced through additional educational efforts like those funded by the TPP Program.[30]

2. The TPP Program supports effective, medically accurate education and services to reduce teenage pregnancy.

Since its inception, the TPP Program has funded 186 programs, reaching approximately 1.7 million youth, including youth of color, those in foster care, and those in rural areas.[31] Many Pennsylvania teenagers and their families, especially from vulnerable and at-risk populations, have likewise accessed effective, evidence-based pregnancy prevention services through the TPP Program.

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[28] Power to Decide, *Progress Pays Off Pennsylvania Savings Fact Sheet* (Jan. 2018), https://powertodecide.org/sites/default/files/cost-fact-sheets/savings-fact-sheet-PA.pdf.

[29] *Pennsylvania Data supra* note 14 and *Pennsylvania Savings Fact Sheet, supra* note 28.

[30] *Pennsylvania Savings Fact Sheet*, *supra* note 28.

[31] *Teenage Pregnancy Prevention: Statistics and Programs supra* note 7 ; *About the Teen Pregnancy Prevention (TPP) Program supra* note 8 *; Teen Pregnancy Prevention Program By the Numbers supra* note 9; *Teen Pregnancy Prevention Program Teens Reached supra* note 9; *Performance Measures Snapshot, The Teen Pregnancy Prevention Program: Performance in Fiscal Year 2017*, *supra* note 9.

Specifically, two Tier 1 grants and four Tier 2 grants totaling $5,539,221 have provided Pennsylvanian teenagers with programs including awareness intervention for African American young men, sexual behavior intervention for high risk female adolescents, and contraception education for African American and Latina teenagers.[32]

These projects funded by the TPP Program are an essential component of efforts to continue reducing the teenage pregnancy rate. Nationwide, the teenage birth rate has been cut almost in half from 37.9 per 1,000 in 2009 to 20.3 births per 1,000 in 2016.[33] In Pennsylvania, the number of teenage pregnancies decreased by more than 50% from 2013 to 2016, down from 14,680 to 6,385.[34] In California, the teen birth rate declined 66% between 2000 to 2016.[35] Efforts to prevent teenage pregnancy in Pennsylvania averted approximately 12,000 teenage births in 2015

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[32] Power to Decide, *Key Information about Pennsylvania* (Jan. 2019), https://powertodecide.org/sites/default/files/resources/supporting-materials/key-Information-pennsylvania.pdf.

[33] Off. of Adolescent Health of the U.S. Dep't of Health & Human Servs., *Trends in Teen Pregnancy and Childbearing* (June 2, 2016), https://www.hhs.gov/ash/oah/adolescent-development/reproductive-health-and-teen-pregnancy/teen-pregnancy-and-childbearing/trends/index.html.

[34] *Pennsylvania Data*, *supra* note 14.

[35] California Department of Public Health, https://www.cdph.ca.gov/Programs/CFH/DMCAH/CDPH%20Document%20Library/Data/Adolescent/Adolescent-Birth-Rates-2016.pdf

alone, based on the decline in the state's teenage birth rate since 1991.[36] Effective, medically accurate projects such as those funded by the TPP Program are essential to the States' efforts to continue reducing teenage pregnancies.

Studies have repeatedly established that comprehensive, medically accurate programs based on evidence rather than ideology are effective in reducing teenage pregnancy.[37] By contrast, abstinence-only programs have been shown to be less effective.[38] As of 2015, 43 percent of teenagers nationwide had engaged in sex at least once.[39] In Pennsylvania, the number was 36.3 percent.[40] These statistics demonstrate that, for some teenagers, programs must go beyond abstinence-only principles to effectively prevent teenage pregnancies. Congress's decision to direct TPP Program funds toward medically accurate approaches while prioritizing

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[36] Power to Decide, *Progress Pays Off*, *supra* note 28.

[37] *See, e.g.*, Gorge C. Patton et. al., *Our Future: A Lancet Commission on Adolescent Health and Wellbeing* tbl.4 (June 11, 2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5832967/; Cora C. Bruener and Gerri Mattson, Am. Acad. of Pediatrics, *Clinical Report, Guidance for the Clinician in Rendering Pediatric Care: Sexuality Education for Children and Adolescents* e2-e7 (Aug. 2016), http://pediatrics.aappublications.org/content/early/2016/07/14/peds.2016-1348.

[38] Our Future, *supra* note 37. *See also* John S. Santelli et. al, 61 J. Adolescent Health 40001 (2017), https://www.jahonline.org/article/S1054-139X(17)30297-5/fulltext#intraref0010a.

[39] Ctr. for Disease Control, *Vital Signs: Preventing Teen Pregnancy* (Apr. 2015), https://www.cdc.gov/vitalsigns/larc/index.html.

[40] *Pennsylvania Data*, *supra* note 14.

rigorously evaluated, evidence-based programming—and to separate those funds from other federal grant programs for abstinence-only projects—is consistent with the recognition that programs that are guided by evidence rather than ideology are far more likely to be effective.

II. The 2018 Funding Opportunity Announcements Disregard Congress's Intent and Will Undermine the States' Efforts to Combat Teen Pregnancy.

Ignoring the TPP Program's carefully crafted statutory scheme, Defendants have sought to fundamentally change the nature of the TPP Program. After efforts to cancel the second cycle of TPP Program grant awards two years early were blocked by several courts,[41] Defendants issued the two FOAs, which significantly alter the criteria for participation in the TPP Program.

The first cycle of TPP Program grants ran from 2010 to 2014, followed by a second cycle running from 2015 to 2019. Grants for both cycles were awarded in accordance with Congress's direction to fund medically accurate programs, including Tier 1 programs that had already been rigorously evaluated and proven

[41] *See King Cnty. v. Azar*, 320 F. Supp. 3d 1167 (W.D. Wash. 2018), *appeal dismissed*, No. 18-35606, 2018 WL 5310765 (9th Cir. Sept. 20, 2018); *Policy & Research LLC v. HHS*, 313 F. Supp. 3d 62 (D.D.C. 2018), *appeal dismissed*, No. 18-5190, 2018 WL 6167378 (D.C. Cir. Oct. 29, 2018); *Healthy Teen Network v. Azar*, 322 F. Supp. 3d 647 (D. Md. 2018); *Planned Parenthood of Greater Wash. & N. Idaho v. HHS*, 328 F. Supp. 3d 1133 (E.D. Wash. 2018); and *Healthy Futures of Tex. v. HHS*, 315 F. Supp. 3d 339 (D.D.C. 2018), *appeal dismissed sub nom. Healthy Futures of Texas v. Dep't of Health & Human Res.*, No. 18-5236, 2018 WL 6167384 (D.C. Cir. Oct. 26, 2018).

effective and Tier 2 programs that could be replicated in the future if proven effective through rigorous research and evaluation. For FY 2018, Congress used the same language in again directing that 75 percent of TPP Program grant funding be awarded to Tier 1 programs, and that the remaining 25 percent be awarded to Tier 2 programs.[42]

However, in complete disregard of Congress's mandate, the 2018 Tier 1 and Tier 2 FOAs abandon any requirement that applicants demonstrate that their programs are medically accurate. The Tier 1 FOA further omits any requirement that applicants show their programs have been proven effective through rigorous evaluation. Instead, the Tier 1 FOA instructs applicants to "replicate a risk avoidance model or a risk reduction model that incorporates the common characteristics" of one of two "tools."[43] It requires applicants to choose either the Center for Relationship Education's Systematic Method for Assessing Risk-

[42] *See* Consol. Appropriations Act, 2018, Pub. L. No. 115-141, 132 Stat 348, 766; Consolidated Appropriations Act, 2010, Pub. L. No. 111-117, 123 Stat 3034, 3253. For FY 2018, "10 percent of the available funds shall be for training and tech. assistance, evaluation, outreach, and additional program support activities, and of the remaining amount 75 percent shall be for replicating programs that have been proven effective through rigorous evaluation to reduce teenage pregnancy, behavioral risk factors underlying teenage pregnancy, or other associated risk factors, and 25 percent shall be available for research and demonstration grants to develop, replicate, refine, and test additional models and innovative strategies for preventing teenage pregnancy."

[43] *Tier 1 FOA*, *supra* note 6, at 4.

Avoidance Tool ("SMARTool")[44] as a "risk avoidance model," or the Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs ("TAC")[45] as a "risk reduction model." Neither "tool" is itself a program or provides any indication of whether a program identified or implemented using the tool has been proven effective through rigorous evaluation. The SMARTool is merely a self-described "resource to curriculum developers and educators and offers methods for comparing different curricula to one another" to "help organizations assess, select, and implement effective programs and curricula that support sexual risk avoidance."[46] Similarly, TAC describes itself as simply an "organized set of questions designed to help practitioners assess whether curriculum-based programs incorporated the common characteristics of effective programs."[47]

In addition, the two FOAs have added a new set of "Expectations of Recipients," including requirements that all projects seeking Tier 1 and Tier 2

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[44] Ctr. For Relationship Educ., *SMARTool: Assessing Potential Effectiveness for Sexual Risk Avoidance Curricula and Programs* (2010), https://www.myrelationshipcenter.org/getmedia/dbed93af-9424-4009-8f1f-8495b4aba8b4/SMARTool-Curricular.pdf.aspx.

[45] Kirby, D., Rolleri, L.A., & Wilson, M.M., *Tool to Assess the Characteristics of Effective STD/HIV Education Programs* (2007), http://recapp.etr.org/recapp/documents/programs/tac.pdf.

[46] SMARTool, *supra* note 44 .

[47] TAC, *supra* note 45.

funding "clearly communicate that teen sex is a risk behavior," "place a priority on providing information and practical skills to assist youth in avoiding sexual risk," and "provide affirming and practical skills" for "cessation" of sexual risk.[48] The FOAs also change the scoring metric, which now allots large percentages of the 100 total available points (up to 25 for Tier 1, and up to 30 for Tier 2) for incorporating these new expected priorities.[49] The FOAs define "sexual risk" as "engaging in any behavior that increases one's risk of the unintended consequences of sexual activity."[50] In the context of teenage pregnancy prevention programing, "sexual risk avoidance" refers to abstinence-only content: for example, a different federal "Sexual Risk Avoidance Educational Program" (SRAEP")[51] is appropriated entirely separately from the TPP Program and, unlike the TPP Program, is used solely "to fund projects to implement sexual risk avoidance education that teaches participants how to voluntarily refrain from non-marital sexual activity."[52]

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[48] 2018 Tier 1 FOA, *supra* note 6, at 14-15; 2018 Tier 2 FOA, *supra* note 6, at 11-13.

[49] 2018 Tier 1 FOA, *supra* note 6, at 59-60; Tier 2 FOA, *supra* note 6, at 53-54.

[50] 2018 Tier 1 FOA, *supra* note 6, at 14-15; 2018 Tier 2 FOA, *supra* note 6, at 11-13.

[51] Social Security Act, 42 U.S.C. § 1310, 1110; Consol. Appropriations Act, 2016, Pub. L. No. 114-113, 129 Stat. 2242.

[52] Family and Youth Serv. Bureau, U.S. Dep't of Health and Human Servs., *Sexual Risk Avoidance Educ. Program Fact Sheet* (Feb. 17, 2017), https://www.acf.hhs.gov/fysb/resource/srae-facts.

These provisions are inconsistent with Congress's clear intent that TPP Program funding decisions guided by science and evaluated based on evidence. They will undermine existing programs that have been proven to be effective while slowing the development of new programs. The FOAs' elimination of criteria requiring Tier 1 applicants to demonstrate their effectiveness through rigorous evaluation, as well as the prioritization of an abstinence-only message over providing medical accurate information in evaluating Tier 1 and Tier 2 applicants, will make it virtually impossible for many highly effective, non-abstinence only programs to receive funds without overhauling their curricula in ways that undermine their effectiveness.

Replacing highly effective programs with ones that are ineffective or unproven will increase the risk of teenage pregnancies and the resulting physical, emotional, and economic harms. Ultimately, the States will bear much of the cost of any reductions in access to effective teenage pregnancy prevention programs and any resulting increase in teenage pregnancies. States will be required to compensate for lost funding with their own resources, or be forced to bear increased expenditures for public assistance payments, public health care, foster care, and criminal justice services as a result of increasing teenage pregnancy rates.

III. Defendants Should Be Prevented From Relying on the 2018 FOAs in Making Future TPP Program Grants.

FOAs play a critical role in the grant-making process. Guidelines issued by the Office of Management and Budget require that FOAs detail "the criteria that the Federal awarding agency will use to evaluate applications" to include "the merit and other review criteria that evaluators will use to judge applications, including any statutory, regulatory, or other preferences." 2 CFR Part 200, app. 1 § E.1. The purpose of requiring such information is "to make the application process transparent so applicants can make informed decisions when preparing their applications to maximize fairness of the process." *Id.* If the FOAs are allowed to stand, applicants that intend to offer programs relying on evidence-based, effective techniques will be forced to modify their programs to utilize less effective methods or—like Plaintiffs here—forego funding entirely. The result will be that grants will be awarded to less effective programs that have not undergone rigorous evaluation and programs that are not medically accurate.

Courts have recognized that a decision to impose grant criteria is subject to judicial review if it "'represents the agency's definitive position on the question.'" *City of Philadelphia v. Sessions*, 280 F. Supp. 3d 579, 615 (E.D. Pa. 2017), *appeal dismissed sub nom.*, *City of Philadelphia v. Attorney Gen. United States*, No. 18-1103, 2018 WL 3475491 (3d Cir. July 6, 2018) (quoting *Univ. of Med. & Dentistry of New Jersey v. Corrigan*, 347 F.3d 57, 69 (3d Cir. 2003)). The harm resulting

from permitting Defendants to utilize the 2018 FOAs in making future grant awards cannot be undone through challenges to specific grant decisions, as some effective providers will chose not to apply and others will modify their programs to align them with the priorities expressed in the FOA. As a result, the injuries to the States can only be addressed by preventing Defendants from relying on the 2018 FOAs in issuing future TPP Program grants. For this reason, this Court should direct the district court to enter summary judgment in favor of Plaintiffs so that Defendants may not contravene Congress's clear intent in issuing future grant awards.

CONCLUSION

The amici States respectfully urge the Court to reverse the district court's decision and direct the district court to enter summary judgment in favor of Plaintiffs.

March 18, 2019

Respectfully submitted,

JOSH SHAPIRO
Attorney General of Pennsylvania

/s Michael J. Fischer
MICHAEL J. FISCHER
Chief Deputy Attorney General
AMBER SIZEMORE
Deputy Attorney General
Office of Attorney General
1600 Arch St., Suite 300
Philadelphia, PA 19103
(215) 560-2171
mfischer@attorneygeneral.gov

XAVIER BECERRA
Attorney General of California
1300 I Street
Sacramento, CA 94244

WILLIAM TONG
Attorney General of Connecticut
55 Elm Street
Hartford, CT 06106

KATHLEEN JENNINGS
Attorney General of Delaware
820 North French Street
Wilmington, DE 19801

KARL A. RACINE
Attorney General
District of Columbia
441 4th Street, N.W.
Washington, D.C. 20001

CLARE E. CONNORS
Attorney General of Hawai'i
425 Queen Street
Honolulu, HI 96813

KWAME RAOUL
Attorney General of Illinois
100 West Randolph Street, 12th Floor
Chicago, IL 60601

THOMAS J. MILLER
Attorney General of Iowa
1305 East Walnut Street
Des Moines, IA 50319

BRIAN E. FROSH
Attorney General of Maryland
200 Saint Paul Place
Baltimore, Maryland 21202

MAURA HEALEY
Attorney General
Commonwealth of Massachusetts
One Ashburton Place
Boston, MA 02108

DANA NESSEL
Attorney General of Michigan
P.O. Box 30212
Lansing, MI 48909

KEITH ELLISON
Attorney General of Minnesota
102 State Capitol
75 Rev. Dr. Martin Luther
King Jr. Blvd.
St. Paul, MN 55155

AARON D. FORD
Attorney General of Nevada
100 North Carson Street
Carson City, NV 89701

GURBIR S. GREWAL
Attorney General of New Jersey
25 Market Street, 8th Floor
Trenton, NJ 08625

LETITIA JAMES
Attorney General of New York
28 Liberty St., 23rd Floor
New York, NY 10005

JOSHUA H. STEIN
Attorney General of North Carolina
North Carolina Department of Justice
114 W. Edenton Street
Raleigh, NC 27603

ELLEN F. ROSENBLUM
Attorney General of Oregon
1162 Court St. NE
Salem, OR 97301

PETER F. NERONHA
Attorney General of Rhode Island
150 South Main Street
Providence, Rhode Island 02903

THOMAS J. DONOVAN, JR.
Attorney General of Vermont
Office of the Attorney General
109 State Street
Montpelier, VT 05609

MARK R. HERRING
Attorney General
Commonwealth of Virginia
202 N. Ninth Street
Richmond, VA 23219

ROBERT W. FERGUSON
Attorney General of Washington
PO Box 40100
Olympia, WA 98504-0100

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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Chief Deputy Attorney General

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