Nos. 25-1698, 25-1755

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.; PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS; PLANNED PARENTHOOD ASSOCIATION OF UTAH,

Plaintiffs-Appellees,

v.

ROBERT F. KENNEDY, JR., in the official capacity as Secretary of the U.S. Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; MEHMET OZ, in the official capacity as Administrator of the Centers for Medicare & Medicaid Services; CENTERS FOR MEDICARE & MEDICAID SERVICES,

Defendants-Appellants.

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

BRIEF FOR APPELLANTS

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REASONS WHY ORAL ARGUMENT SHOULD BE HEARD

The district court entered preliminary injunctions prohibiting the government from enforcing an Act of Congress that establishes a new limit on how federal Medicaid funds may be spent. Those injunctions interfere with Congress's authority over federal spending and trench on the Executive's authority to enforce the law. This Court has scheduled oral argument in these consolidated appeals for November 12, 2025.

INTRODUCTION

The district court enjoined the enforcement of an Act of Congress based on the implausible theory that Congress's effort to prevent federal funds from subsidizing abortion, directly or indirectly, constitutes a bill of attainder and a restriction on expressive activity. Congress's enactment is a prospective funding limitation, not a bill of attainder, and its application to subsidiaries and affiliates of entities that provide abortions has nothing to do with expression and instead prevents the use of the corporate form to evade the funding limit. A unanimous panel of this Court properly issued a stay pending appeal to allow this duly enacted statute to take effect, and this Court should now reverse the preliminary injunctions outright.

Abortion is a controversial practice. Many Americans find it abhorrent, while others—like the plaintiffs here—think that abortion should be readily available. After the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215 (2022), policy questions about abortion are left to the political process.

Here, the political branches have spoken. Congress enacted, and the President signed into law, a statute that restricts federal Medicaid funding of major abortion providers, thus preventing federal funds from indirectly subsidizing abortions provided by those entities. Plaintiffs may disagree with that policy choice, but there is no plausible constitutional basis for overturning it. *See Family Plan. Ass'n of Me. v. U.S. Dep't of Health & Human Servs.*, No. 25-cv-364, 2025 WL 2439209, at *8 (D. Me. Aug. 25, 2025) (recognizing that plaintiffs' "convictions are not equal to the task of

enjoining congressional will in this arena"), *appeal filed*, No. 25-1829 (1st Cir. Sep. 2, 2025).

STATEMENT OF JURISDICTION

Plaintiffs invoked the district court's jurisdiction under 28 U.S.C. § 1331. A119. The district court entered a preliminary injunction on July 21, 2025, A6, and the government timely appealed on July 22, 2025, A563. The district court entered a second, expanded preliminary injunction on July 28, 2025, A42, and the government timely appealed on August 5, 2025, A566. This Court has jurisdiction over the consolidated appeals under 28 U.S.C. § 1292(a)(1).

STATEMENT OF THE ISSUES

This case involves appeals from preliminary injunctions barring the government from enforcing an Act of Congress. Under Section 71113 of the Reconciliation Act of 2025, federal Medicaid funds cannot be distributed to "prohibited entities," a term defined by reference to whether, as of October 1, 2025, an entity meets various conditions, including the condition that it perform abortions. Pub. L. No. 119-21, 139 Stat. 72, 300. A "prohibited entity" is "an entity, including its affiliates, subsidiaries, successors, and clinics," that meets the statutory conditions. *Id.* Plaintiffs—Planned Parenthood Federation of America, Inc. (PPFA) and two of its members—challenge the statute on bill-of-attainder, First Amendment, and equal-protection theories. The questions presented are:

1. Whether the district court erred in concluding that a prospective and generally applicable limit on Medicaid funding amounts to a bill of attainder;

2. Whether the district court erred in concluding that Section 71113, which applies without regard to expression, violates the First Amendment and equal-protection principles; and,

3. Whether the district court erred in concluding that the equities justify injunctions compelling the government to distribute taxpayer dollars to major abortion providers notwithstanding the elected Branches' contrary determination.

STATEMENT OF THE CASE

A. Statutory Background

In 1965, Congress passed, and President Johnson signed into law, the Medicaid program. *See* 42 U.S.C. § 1396 *et seq.* Medicaid is a cooperative federal-state program in which the federal government supplies funding to States to assist them in providing medical assistance to specified categories of low-income individuals. *See Medina v. Planned Parenthood S. Atl.*, 145 S. Ct. 2219, 2226-27 (2025). Those federal funds are not distributed to individuals directly. Instead, the States pay healthcare providers (or health plans in managed-care delivery systems) for care furnished to eligible individuals, and then the States seek federal funding from the Department of Health and Human Services to cover a portion of the State's expenditures. *See* 42 U.S.C. §§ 1396a, 1396b.

Since its inception, the Medicaid statute has included numerous restrictions on how taxpayer dollars are spent. *See*, *e.g.*, 42 U.S.C. § 1396b(i) (restricting funding for organ transplants). And Congress has expressly reserved "[t]he right to alter, amend, or repeal" any aspect of the program. *Id.* § 1304. Congress has periodically enacted new legislation to account for changes in the marketplace and to align the Medicaid program with new priorities. For example, every year since 1977, Congress has passed an appropriations provision, commonly known as the Hyde Amendment, that "prohibit[s] . . . the use of any federal funds to reimburse the cost of abortions under the Medicaid program except under certain specified circumstances." *Harris v. McRae*, 448 U.S. 297, 302 (1980) (footnote omitted); *see* Edward C. Liu & Wen W. Shen, Cong. Rsch. Serv., IF12167, *The Hyde Amendment: An Overview* (2022). That funding restriction has been upheld by the Supreme Court. *See Harris*, 448 U.S. at 326.

Congress once again revisited and amended the Medicaid program as part of the Reconciliation Act of 2025, which President Trump signed into law on July 4, 2025. Pub. L. No. 119-21, 139 Stat. 72. Section 71113 of the Act establishes that no federal Medicaid funds "shall be used to make payments to a prohibited entity for items and services furnished during the 1-year period beginning on the date of the enactment of this Act." 139 Stat. at 300. Congress defined a "prohibited entity" as "an entity, including its affiliates, subsidiaries, successors, and clinics—

> that, as of the first day of the first quarter beginning after the date of enactment of this Act [October 1, 2025]—

> is an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code;
>
> is an essential community provider described in section 156.235 of title 45, Code of Federal Regulations (as in effect on the date of enactment of this Act), that is primarily engaged in family planning services, reproductive health, and related medical care; and
>
> provides for abortions, other than an abortion—
>
> > if the pregnancy is the result of an act of rape or incest; or
> >
> > in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed; and
>
> for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act for medical assistance furnished in fiscal year 2023 made directly, or by a covered organization, to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded $800,000.

Id.[1]

B. Prior Proceedings

1. Plaintiffs are Planned Parenthood Federation of America, Inc. (PPFA), which is a membership organization, and two of its members, Planned Parenthood League of Massachusetts and Planned Parenthood Association of Utah. A120-26. Plaintiffs assert that Section 71113 is facially unconstitutional on bill-of-attainder,

[1] For the sake of brevity, when this brief uses the term "abortion," it refers to abortions other than those excluded by Section 71113.

Fifth Amendment equal-protection, and First Amendment retaliation grounds. A151-56. Plaintiffs also claim that Section 71113's inclusion of entities' "affiliates" impinges on First Amendment association and thereby violates the unconstitutional-conditions doctrine. A158-59.

2. On the same day that plaintiffs initiated this suit, they moved for a temporary restraining order (TRO) and a preliminary injunction. A102. Hours later, the district court issued an *ex parte* temporary restraining order without providing any reasoning. Dkt. No. 18. After the government moved to dissolve the TRO based on procedural defects, Dkt. No. 29, the court issued an amended TRO, Dkt. No. 46. Despite analyzing plaintiffs' likelihood of success only as to Section 71113's application to entities that would qualify as prohibited entities solely due to the statute's affiliates provision—a group plaintiffs suggest is small—the amended TRO barred the government from enforcing the statute against any Planned Parenthood member. Dkt. No. 46, at 6-7.

Following a hearing, the district court first granted Planned Parenthood's preliminary-injunction motion in part and later granted it in full. In its initial preliminary-injunction order, the court reasoned that Section 71113's reference to "affiliates" intrudes on the expressive association protected by the First Amendment. A21-31. Relying on that premise, the court concluded that plaintiffs had shown a likelihood of success on their unconstitutional-conditions and equal-protection claims. *Id.* The court did not reach plaintiffs' other claims. It believed that the equities

favored plaintiffs in large part because it viewed them as having demonstrated a "First Amendment injury." A32. Because the court's First Amendment theory only pertained to PPFA members that may be subject to the funding condition only because of their status as affiliates, it limited the injunction to those affiliates. A38-39.

Shortly thereafter, the district court granted plaintiffs' preliminary-injunction motion in full. A40. The court reiterated its theory that Section 71113's reference to an entity's "affiliates" impinges on the First Amendment's protection of expressive association and therefore contravenes unconstitutional-conditions and equal-protection principles. A62-69. This time, however, the court indicated that it now viewed the theory as supporting relief for "all" PPFA members, not just the small number that may be covered only due to the affiliate provision. A42. For the first time, the court also characterized Section 71113 as a bill of attainder. It declared that withholding federal Medicaid funds "is consistent with historical notions of punishment" such as "imprisonment, banishment, and the punitive confiscation of property." A76. Turning to the equities, the court again relied chiefly on its view that Section 71113 "injures constitutional rights." A91. The court then entered a second preliminary injunction prohibiting the government from applying Section 71113 to any PPFA member. A96-97.

Although the district court denied the government's motion to stay the injunctions pending appeal, a unanimous panel of this Court entered a stay. The Court stated that "[n]otwithstanding the contrary conclusion reached by the district

court," the government had "met [its] burden to show [its] entitlement to a stay of the preliminary injunctions." Sept. 11 Order. The Court also unanimously denied plaintiffs' motion for reconsideration of the stay order and instead entered an expedited briefing schedule. Sept. 18 Order.

SUMMARY OF ARGUMENT

Section 71113 reflects a permissible exercise of Congress's broad power over federal spending. Under that Section, federal Medicaid funds cannot be paid to prohibited entities, a term defined by reference to whether, as of several months after the statute's enactment, an entity satisfies various conditions, including the condition that it performs certain abortions. All three democratically elected parts of the federal government—both Houses of Congress and the President—thus concluded that federal Medicaid funds should no longer subsidize major abortion providers. The district court nonetheless believed that Section 71113 is inconsistent with the Bill of Attainder Clause and the First and Fifth Amendments and entered preliminary injunctions barring the statute's enforcement against plaintiffs and their members. That was error. Section 71113 easily passes constitutional muster, and rarely if ever has an Act of Congress been enjoined on such implausible grounds.

I. Section 71113 is not a bill of attainder. The Supreme Court has applied the Bill of Attainder Clause to invalidate an Act of Congress only five times in the Nation's history—on each occasion in cases involving extraordinary laws punishing groups such as Confederates and Communist Party members. Halting the flow of

federal Medicaid funds bears no resemblance to the severe punishments—including death, banishment, and imprisonment—previously understood as implicating the Clause. Instead, Section 71113 resembles various laws withholding federal financial benefits that the Supreme Court has confirmed do not impose punishment. The funding restriction is also not a bill of attainder for the independent reason that it avoids designating individuals for punishment and instead adopts a forward-looking and generally applicable definition of prohibited entities.

Plaintiffs' First Amendment theory is similarly meritless. The district court appeared to recognize that the core statutory provisions, which define entities prohibited from receiving federal Medicaid funding without regard to any expressive activity, do not implicate the First Amendment. It nonetheless believed that an ancillary provision extending the funding restriction to those entities' "subsidiaries" and "affiliates" transforms the entire enactment into an intrusion on constitutionally protected association. But the funding restriction ensures that entities and affiliates who pool resources to some degree do not thereby circumvent Congress's policy against subsidizing certain abortion providers. Congress often promulgates similar provisions that ensure that the corporate form does not defeat statutory limitations, and those provisions have never been understood as raising First Amendment concerns. In any event, any concerns regarding the statute's affiliate provision would not justify the court's injunctions, which sweep far beyond the entities that may be affected by that provision. And the court's Fifth Amendment theory, to the extent it

was not derivative of its flawed First Amendment theory, cannot be reconciled with the rational-basis standard or the self-evident legitimate bases for the statute.

II. Because plaintiffs have failed to demonstrate a likelihood of success on the merits, the preliminary injunctions should be vacated. The remaining factors confirm that conclusion. Compelling the federal government to distribute taxpayer dollars to prohibited entities interferes with Congress's Article I authority over federal spending and trenches on the Executive's Article II authority to enforce the law. That interference is especially harmful here, where the injunctions override the elected Branches' resolution of a significant and contested questions of public policy by forcing the government to fund entities that provide abortions—conduct that many Americans find abhorrent or otherwise do not wish to subsidize. By contrast, plaintiffs' harms warrant little if any weight. Plaintiffs have no cognizable interest in obtaining federal funds to which they are not legally entitled.

STANDARD OF REVIEW

This Court reviews the district court's decision to enter a preliminary injunction for abuse of discretion. *OfficeMax, Inc. v. Levesque*, 658 F.3d 94, 97 (1st Cir. 2011). Where the district court's analysis is premised on an error of law, the court "has abused its discretion and [this Court is] required to vacate the injunction." *Doe v. Trustees of Bos. Coll.*, 942 F.3d 527, 533 (1st Cir. 2019).

ARGUMENT

A preliminary injunction is "an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief." *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 22 (2008). Here, plaintiffs come nowhere near establishing "a strong likelihood that they will ultimately prevail on the merits." *Alliance Freedom Def. Initiative v. Massachusetts Bay Transp. Auth.*, 781 F.3d 571, 578 (1st Cir. 2015). Nor have plaintiffs shown that the equities justify injunctions compelling the government to distribute federal taxpayer dollars to entities that Congress deemed ineligible to receive them. The district court erred in concluding that plaintiffs satisfy the requirements for interim injunctive relief.

I. Plaintiffs Have Failed To Demonstrate A Likelihood Of Success On The Merits

A. Section 71113 Is Not A Bill Of Attainder

The Supreme Court has only applied the Bill of Attainder Clause to hold a statute unconstitutional on five occasions, all of which involved extraordinary laws concerning Confederates, Communist Party members, or "subversives." *See Elgin v. U.S. Dep't of the Treasury*, 641 F.3d 6, 19 (1st Cir. 2011) (Stahl, J., concurring) (collecting cases). Plaintiffs' lead argument in this case is nonetheless that the federal Medicaid funding restriction qualifies as a bill of attainder. To support that claim, plaintiffs must show that Section 71113 (1) "inflicts punishment" and (2) "upon an

identifiable individual." *Selective Serv. Sys. v. Minnesota Pub. Int. Rsch. Grp.*, 468 U.S. 841, 846-47 (1984). Plaintiffs clear neither hurdle.

1. Section 71113 "reasonably can be said to further" Congress's "nonpunitive legislative purpose[]" of halting federal Medicaid funding for abortion providers. *Nixon v. Administrator of Gen. Servs.*, 433 U.S. 425, 475-76 (1977). Under Article I of the Constitution, Congress holds "broad discretion" to control federal spending by "impos[ing] limits on the use of such funds to ensure they are used in the manner Congress intends." *Agency for Int'l Dev. v. Alliance for Open Soc'y Int'l, Inc.* (*AID*), 570 U.S. 205, 213 (2013). Thus, any "review of distinctions that Congress draws in order to make allocations from a finite pool of resources must be deferential, for the discretion about how best to spend money to improve the general welfare is lodged in Congress rather than the courts." *Lyng v. International Union, United Auto., Aerospace & Agric. Implement Workers of Am.*, 485 U.S. 360, 373 (1988).

Congress has repeatedly exercised its authority over federal spending by imposing limits on the Medicaid program, including most recently by enacting Section 71113. Under that Section, federal Medicaid funds cannot be distributed to "prohibited entities," a term defined by reference to whether, as of October 1, 2025, an entity provides abortions, "is an organization described in section 501(c)(3) of the Internal Revenue Code," is an essential community provider primarily engaged in certain functions, and received over $800,000 in federal and state Medicaid funds in

2023. 139 Stat. at 300. In combination, these requirements capture a category of major abortion providers that Congress did not wish to fund.

Halting the flow of federal Medicaid funds to these entities bears no resemblance to the forms of punishment that implicate the Bill of Attainder Clause. Historically, bills of attainder involved punishments such as "death," "banishment," and "imprisonment." *Selective Serv.*, 468 U.S. at 852. By contrast, the "withholding of appropriations" is not "a traditional form of punishment that is considered to be punitive per se." *ACORN v. United States*, 618 F.3d 125, 137 (2d Cir. 2010). The Second Circuit, for example, has rejected a bill-of-attainder challenge to appropriations laws withholding federal funds from ACORN, a nonprofit corporation, and its affiliates. *See id.* at 131. The court explained that "[i]n comparison" to historical punishments, "a temporary disqualification from funds . . . may be more an inconvenience than [a] punishment." *Id.* at 137.

The Supreme Court has repeatedly recognized that withdrawing federal financial benefits does not amount to punishment. For example, in rejecting a bill-of-attainder challenge to a statute denying federal financial aid to individuals who failed to register for the Selective Service, the Court emphasized that such withholding does not "approach[] the 'infamous punishment' of imprisonment or other disabilities historically associated with punishment." *Selective Serv. Sys.*, 468 U.S. at 853 (quoting *Flemming v. Nestor*, 363 U.S. 604, 617 (1960)). Likewise, in rejecting a challenge to a statute terminating Social Security benefits for individuals deported under the

immigration laws, the Court observed that the "mere denial of a noncontractual governmental benefit" does not qualify as punishment. *Nestor*, 363 U.S. at 617. Under these precedents, the federal Medicaid funding restriction at issue here raises no bill-of-attainder concern.

Section 71113 is even less like punishment than some funding restrictions, *see, e.g*, *ACORN*, 618 F.3d at 137, because its application depends not on past acts but on future conduct. As noted, the statute defines prohibited entities based on whether they meet various requirements "as of" several months after the statute's enactment. 139 Stat. at 300. Thus, the statute "d[oes] not even deprive" anyone of federal Medicaid funds "permanently." *Selective Serv. Sys.*, 468 U.S. at 853. Instead, in a "nonpunitive spirit," it "allow[s] all" providers to avoid the law's application, *id.* at 855, solely by altering their future conduct (for example, by ceasing to provide abortions, among other possibilities) to avoid a pause in federal Medicaid payments for a single year. A statute that specifies the conditions for receiving federal funding in the future has nothing in common with the severe and backward-looking punishments that may run afoul of the Bill of Attainder Clause.

In nonetheless concluding that Section 71113 imposes punishment, the district court relied on a strained comparison between that provision and historical laws "barring designated . . . groups from participation in specified employments." A76 (July 28 Order) (quoting *Nixon*, 433 U.S. at 474). That comparison fails on many levels: serving Medicaid patients is not a profession, plaintiffs remain free to provide

healthcare to anyone they choose, and they can even receive federal Medicaid funds to do so if they cease performing abortions. At most, Section 71113 could be analogized to a permissible "line-of-business restriction," under cases recognizing that "'the Bill of Attainder Clause tolerates statutes that, in pursuit of legitimate goals such as public safety or economic regulation, prevent companies from engaging in particular kinds of business or particular combinations of business endeavors.'" *TikTok Inc. v. Garland*, 122 F.4th 930, 968 (D.C. Cir. 2024) (quoting *Kaspersky Lab, Inc. v. United States Dep't of Homeland Sec.*, 909 F.3d 446, 463 (D.C. Cir. 2018)), *aff'd on other grounds*, 604 U.S. 56 (2025) (per curiam). Like a line-of-business restriction, Section 71113 is not remotely "analogous to a legislative bar on someone's participation in a specific employment or profession." *Id.*

The extent of the district court's error is exemplified by the Civil War-era case on which it relied. *See* A77 (citing *Cummings v. Missouri*, 71 U.S. (4 Wall.) 277 (1866)). In *Cummings*, the Supreme Court invalidated a state law creating an "absolute barrier[] to entry into certain professions for those who could not file the required loyalty oaths; no one who had served the Confederacy could possibly comply." *Selective Service*, 468 U.S. at 850-51 (citing *Cummings*, 71 U.S. (4 Wall.) at 317). By contrast, Section 71113 simply requires prohibited entities to carry on without further federal Medicaid subsidies (or to stop providing abortions and continue receiving such

funds). "Forbidden legislative punishment is not involved merely because [a statute] imposes burdensome consequences." *Nixon*, 433 U.S. at 472.

It was likewise error for the district court to declare that because longstanding federal law "already bars federal funding of elective abortion," Section 71113 "does little to further its purported non-punitive ends." A78. First, "[m]oney is fungible." *Holder v. Humanitarian L. Project*, 561 U.S. 1, 31 (2010). Supplying federal funds to abortion providers for their "other" activities or to their "affiliates" allows them to shift resources to perform the abortions that are nominally not federally funded. The Constitution does not require Congress to "elevate[] form over substance by making the application of" its funding restrictions "dependent on the manner in which a program or activity receives federal assistance." *Grove City Coll. v. Bell*, 465 U.S. 555, 564 (1984). Second, even apart from subsidizing abortions, Congress was entitled to act on a policy "favoring childbirth over abortion," *Rust v. Sullivan*, 500 U.S. 173, 192 (1991) (quotation marks omitted), by withholding federal Medicaid funds from entities that provide abortions, which is not constitutionally protected activity, *see Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 232 (2022). Notably, multiple states have similarly concluded that a policy against funding or supporting abortions warrants declining to subsidize any activities of organizations that provide abortions. *E.g., Medina v. Planned Parenthood S. Atl.*, 145 S. Ct. 2219, 2227 (2025) (discussing a

South Carolina law of this kind); *Planned Parenthood v. Hodges*, 917 F.3d 908, 910 (6th Cir. 2019) (en banc) (discussing a similar Ohio law).

Similarly unfounded is the district court's attempt to ascribe to Congress an "intent to punish." A79. "[O]nly the clearest proof could suffice" to establish that a law qualifies as a bill of attainder on this "dubious" ground, *Nestor*, 363 U.S. at 617—a standard that the Supreme Court has never found met by any statute. Yet the district court grounded its conclusion regarding Congressional intent in "the least illuminating forms" of evidence. *NLRB v. SW Gen., Inc.*, 580 U.S. 288, 307 (2017). "[F]loor statements by individual legislators" are hardly a reliable guide to the intent of a 535-member body. *Id.* For similar reasons, bills introduced in 2017 and 2023, *see* A79, shed little light on a statute enacted years later and, if anything, only underscore the different approach Congress took in Section 71113, *see Communist Party of the U.S. v. Subversive Activities Control Bd.*, 367 U.S. 1, 84-85 (1961) (relying on prior bills that "would have applied to the Community Party by name" improperly "ignores the crucial constitutional significance of what Congress did when it rejected the approach of outlawing the Party by name and accepted instead a statutory program regulating not enumerated organizations but designated activities"); *cf. Abbott v. Perez*, 585 U.S. 579, 604-05 (2018) (declining to infer intent based on legislative acts two years previously). The district court's emphasis (A582) on the fact that Section 71113 does not withhold funds from every "entit[y] that provide[s] legal abortion services" is

similarly irrelevant given Supreme Court precedent recognizing that underinclusion is not persuasive evidence of punitive intent, *see Nestor*, 363 U.S. at 620.

Regardless, the statements and bills on which the district court relied are consistent with Congress's nonpunitive objective of halting federal subsidies for major abortion providers. For instance, the statement that the "legislation offers an important opportunity to stop funding abortion purveyors like Planned Parenthood" uses PPFA as an example of the sort of entities that will likely be affected but also emphasizes the focus on the conduct that the speaker no longer wished to subsidize. A80 (quoting 171 Cong. Rec. E255 (daily ed. Mar. 27, 2025) (statement of Rep. Christopher H. Smith)). Likewise, Speaker Johnson's statement that "this bill is going to redirect funds away from Big Abortion" is fully consistent with Congress's nonpunitive objective of halting the flow of federal taxpayer dollars to major abortion providers. A60 (citation omitted). These statements only buttress the conclusion that Section 71113 "is intended to prevent future action rather than to punish past action." *American Commc'ns Ass'n v. Douds*, 339 U.S. 382, 414 (1950). The statute does not punish plaintiffs for their past activities but rather declines to allocate taxpayer dollars to subsidize the future performance of abortions by plaintiffs and other major abortion providers.

2. Section 71113 is also not a bill of attainder because it refrains from singling out "identifiable individual[s]" for punishment. *Nixon*, 433 U.S. at 468. To qualify as an attainder, a statute must specify an individual "by name" or describe an individual

"in terms of conduct which, because it is past conduct, operates only as a designation of particular persons." *Communist Party*, 367 U.S. at 86. By contrast, statutes establishing "generally applicable rule[s]" that regulate "any person who commits certain acts or possesses certain characteristics" are not bills of attainder. *United States v. Brown*, 381 U.S. 437, 450 (1965). In *Communist Party*, for example, the Supreme Court found the necessary specification lacking where the statute "attaches not to specified organizations but to described activities in which an organization may or may not engage." 367 U.S. at 86. And in *Selective Service System*, the Court likewise found no constitutionally suspect specification in a statute denying federal aid to students who failed to register for the draft, which did not attach to "past and ineradicable actions" because students could register late. 468 U.S. at 851.

Plaintiffs complain that a large fraction of the organizations affected by the statute are likely to be PPFA members. But by plaintiffs' own account, Planned Parenthood members serve "millions of people," and "collectively" form "the only nationwide abortion provider," A114, A116. It is natural that in seeking to prevent federal taxpayer funding for major abortion providers, Congress would adopt a limitation that applies to "the only nationwide abortion provider," *id.*, in addition to a few other entities with similar characteristics, *see, e.g.*, *Family Plan. Ass'n of Me. v. U.S. Dep't of Health & Hum. Servs.*, No. 1:25-cv-00364, 2025 WL 2439209, at *1 (D. Me. Aug. 25, 2025) (denying a motion to preliminarily enjoin Section 71113 filed by Maine

Family Planning, an entity that operates a network of more than 60 clinics and serves tens of thousands of patients a year), *appeal filed*, No. 25-1829 (1st Cir. Sep. 2, 2025).

There is no room for dispute that Section 71113 avoids designating individuals for punishment and instead establishes a "generally applicable rule" regulating entities that "commit[] certain acts." *Brown*, 381 U.S. at 450. "So long as the incidence of legislation is such that the persons who engage in the regulated conduct . . . can escape regulation merely by altering the course of their own present activities, there can be no complaint of an attainder." *Communist Party*, 367 U.S. at 88. That is the case here: because Section 71113 turns on whether an entity meets various requirements "as of" several months after the Section's enactment, 139 Stat. at 300, plaintiffs "can escape regulation" by altering their activities, *Communist Party*, 367 U.S. at 88. Most obviously, plaintiffs could cease to provide abortions. In addition, they could instead relinquish Section 501(c)(3) or essential-community-provider status.

The district court largely disregarded this aspect of Section 71113 and failed to distinguish the governing Supreme Court decisions. It acknowledged that the statute makes funding dependent on whether an entity "provides elective abortion as of October 1," 2025—*i.e.*, future activity. A73. It mistakenly fixated, however, on the fact that the universe of entities subject to that prospective requirement is determined in part by reference to a "retrospective characteristic[]"—namely, whether an entity received "$800,000 in Medicaid reimbursements in 2023." A73 (citing 139 Stat. at 300). But no one could view this provision as reflecting an attempt to single out and

punish entities that previously received a certain amount of federal and state Medicaid funding. Rather, it limits the scope of a nonpunitive regulation of future conduct by exempting entities that previously obtained only relatively small amounts of Medicaid funding. That does not even arguably make it a bill of attainder. Such consideration of past conduct has never been understood as implicating the Clause's identification requirement. In *Communist Party*, for example, "activity engaged in prior to the enactment of the legislation [could] be regarded administratively and judicially as relevant" in determining whether the challenged law applied to a given entity. 367 U.S. at 87. The Supreme Court nevertheless concluded that the law permissibly "turn[ed] upon continuing contemporaneous fact"—not "past and ineradicable actions"—because its application "endure[d] only so long as[] an organization presently conducts operations of a described character." *Id.*

At bottom, the district court appeared to view Section 71113 as an "'unusual'" statute warranting special skepticism because "some legislators" expected that the provision would apply to many (or all) Planned Parenthood members if they continued to act as "'abortion purveyors.'" A80, A83 (citations omitted). The Supreme Court rejected such reasoning in *Communist Party*, which denied a bill-of-attainder challenge even though "legislators who voted for the Act in its final form expected that the Communist Party, if it continued to engage in the activities which had been reported to Congress as characterizing its past conduct, would be" subject

to the statute. 367 U.S. at 84. As *Communist Party* illustrates, it is not unusual for Congress to legislate with a particular example in mind and to draw a statute's boundaries in a way that will predictably include that example. Unless Congress takes the additional step of defining a punitive enactment so that a particular entity is "irreversibl[y]" included, the Bill of Attainder Clause does not apply. *Selective Serv.*, 468 U.S. at 851.

B. Plaintiffs' Other Claims Are Meritless

Plaintiffs' remaining claims largely rest on the flawed premise that the federal funding restriction impinges on the First Amendment. Plaintiffs urge that Section 71113's anodyne reference to an entity's "affiliates" and "subsidiaries" transforms the entire Section into an intrusion on expressive association. But Section 71113's affiliate provision raises no First Amendment concern at all, much less a concern that would justify the entry of an expansive injunction covering all PPFA members. And without any infringement of a fundamental right, Section 71113 easily passes equal-protection scrutiny because it rationally advances the government's legitimate interests in avoiding subsidizing major abortion providers.

1. Plaintiffs do not contend that Section 71113's core provisions implicate the First Amendment. As discussed, those provisions halt federal Medicaid funding to prohibited entities, a term that is defined without regard to any form of expression and that instead depends on an entity's nonexpressive conduct, including its provision

of abortions. Thus, neither plaintiffs nor the district court have suggested that Section 71113's ordinary operation raises any First Amendment concern.

Instead, plaintiffs seize on part of Section 71113 that prevents prohibited entities from using the corporate form to evade the funding restriction. Congress specified that a prohibited entity is "an entity, including its affiliates, subsidiaries, successors, and clinics" that meets the statutory requirements. 139 Stat. at 300. Without this provision, a prohibited entity with subsidiaries or affiliates that obtain federal Medicaid funds could frustrate Congress' objective of withholding taxpayer dollars from certain large abortion providers. Section 71113's reference to affiliates thus has nothing to do with First Amendment association and instead ensures that the federal funding limitation cannot be defeated by corporate structure. In general, an affiliate is a "corporation that is related to another corporation by shareholdings or other means of control." *Affiliate*, Black's Law Dictionary (12th ed. 2024). Congress has included similar definitions in various statutory provisions referring to an entity's affiliates. *See, e.g.*, 12 U.S.C. § 1841(k) ("[T]he term 'affiliate' means any company that controls, is controlled by, or is under common control with another company."). This understanding of an affiliate fits well here, where Section 71113 refers not just to affiliates but also to "subsidiaries, successors, and clinics." Each of those entities is

normally subject to the control of another company and could therefore be used to obtain Medicaid funds despite that company's provision of abortion.

Section 71113's affiliate provision reflects that a prohibited entity (including its affiliates) can be understood as a single enterprise in which funds given to any one affiliate can benefit the entire enterprise. Here, for example, plaintiffs' own declarations reveal that PPFA collects dues from its members and then subsidizes those members in various ways, including not only by redistributing funds but also by providing "practical support," including "technical assistance," "consultant service," and "fundraising support." A172. Federal funds provided to one PPFA member can thus benefit other members, undermining Congress's objective of preventing subsidies to major abortion providers.

Congress often includes similar provisions in federal statutes, and those provisions have never been regarded as raising First Amendment concerns. Some parts of the Internal Revenue Code and Employee Retirement Income Security Act regulate all corporations subject to the same "control." 26 U.S.C. § 414(b); *see* 29 U.S.C. § 1301(a)(14). Other provisions extending statutory requirements to regulated entities' affiliates pervade the United States Code. *See, e.g.*, 50 U.S.C. § 4611(b) (extending sanctions for export-control violations to any "affiliate, subsidiary, and successor" of the sanctioned entity); 16 U.S.C. § 620e(5) (extending conservation requirements to "any subsidiary, subcontractor, or parent company, and [certain] business affiliates" of covered entities); 42 U.S.C. § 16452(b) (extending record-

keeping requirements for public-utility holding companies to "[e]ach affiliate" or "subsidiary" of those companies). The government is unaware of any decision casting doubt on the constitutionality of such provisions.

That is unsurprising in light of fundamental First Amendment principles. As the Supreme Court has explained, incidental burdens on expression do not implicate the First Amendment where the government regulates for reasons unrelated to expression. *See Arcara v. Cloud Books, Inc.*, 478 U.S. 697, 707 (1986). In *Arcara*, for instance, businessowners brought a First Amendment challenge to a statute "authorizing closure of a premises found to be used as a place for prostitution" because the establishment subject to closure "[was] also used as an adult bookstore." *Id.* at 698. In rejecting that challenge, the Court explained that a statute does not raise First Amendment concerns "simply because" it "will have some effect on the First Amendment activities of those subject to" the statute. *Id.* at 706. Instead, constitutional scrutiny applies "only where it [i]s conduct with a significant expressive element that drew the legal remedy in the first place" or "where a statute based on a nonexpressive activity has the inevitable effect of singling out those engaged in expressive activity." *Id.* at 706-07. Neither of those conditions is met here. Providing abortions is not "conduct with a significant expressive element"; nor is corporate affiliation. And Section 71113 does not "singl[e] out those engaged in expressive activity." It applies regardless of whether a prohibited entity engages in expressive

activity, and it has no application to many entities that engage in abortion-related advocacy.

2. The district court's contrary approach misunderstands Supreme Court precedent and Section 71113 itself. At times, the court appeared to suggest that any statutory reference to affiliates amounts to an intrusion on expressive association. *See* A26. Under this theory, the numerous federal and state laws that refer to corporate subsidiaries and affiliates would be subject to stringent review under the First Amendment. For example, the district court's logic indicates that if PPFA triggered the export-control ban, *see* 50 U.S.C. § 4611(b), that longstanding provision of federal law could not be constitutionally applied to PPFA affiliates. Indeed, the court's theory implies that even Section 71113's reference to an entity's "subsidiaries" would trigger heightened scrutiny. 139 Stat. at 300. The First Amendment does not create a system in which Congress can withhold federal funds from specified entities but is powerless to prevent subsidies to those entities' affiliates and subsidiaries.

The Supreme Court cases that the district court cited highlight the absence of support for its approach. *See* A67-68 (first citing *Regan v. Taxation With Representation of Washington*, 461 U.S. 540 (1983); and then citing *FCC v. League of Women Voters of Cal.*, 468 U.S. 364 (1984)). Those cases involved laws requiring the recipients of federal funds to forgo expressive activities, including lobbying, *see Regan*, 461 U.S. at 542, and "editorializing," *FCC*, 468 U.S. at 366. In both cases, the Supreme Court recognized that the resulting First Amendment concerns would be alleviated if the government

allowed the regulated entities to lobby and editorialize through their affiliates. *See Regan*, 461 U.S. at 543; *FCC*, 468 U.S. at 400-01. That principle has no bearing here, where Section 71113 does not require recipients of federal Medicaid funds to refrain from any expressive activity.

Other aspects of the district court's orders improperly conflate Section 71113's reference to an entity's affiliates with a regulation of "Planned Parenthood Federation['s]" "membership." A69. The court declared that "membership in [PPFA] is expressive" and emphasized that members collaborate to "advocate[] before Congress," "communicate[] with the public," and "support[political] campaigns." A65-66. But none of that matters to Section 71113. If PPFA members wish to collaborate for the purpose of advocacy, praise or endorse each other publicly, or participate in events, doing so will not affect the application of the statute. Congress was instead concerned with the nonexpressive activities of corporate control and financing of an enterprise that provides abortions.

Similarly beside the point is the district court's discussion of PPFA's licensing policy. The court highlighted that "each Member licenses the use of the Planned Parenthood name, which expresses that each Member stands for particular values." A66. The statute is not premised on that licensure, but rather on the distinct concept

of affiliation. To the extent that these concepts might overlap in this particular case, that does not transform the statute into a regulation of expression.

Despite the district court's repeated suggestion (A32, A65, A69) that PPFA membership is expressive, it failed to identify any instance in which determining whether an entity is an affiliate would depend on expressive activity. That is unsurprising, as analyzing whether entities are corporate affiliates necessarily turns on evidence of control, not joint expression. For example, in separate litigation PPFA has submitted a declaration indicating that in some instances PPFA determines the services its members offer, including by mandating that those members provide contraception, contraceptive counseling, and abortion. Decl. of Kimberly Custer in Supp. of Pls.' Mot. for Prelim. Inj., ¶ 17, *Planned Parenthood Federation of Am., Inc. v. Azar*, No. 1:19-cv-5435 (S.D.N.Y. June 17, 2019), Dkt. No. 27-2. PPFA's control of its members' provision of medical services is plainly relevant to whether those members qualify as affiliates but has nothing to do with expression.

To the extent the district court believed that Section 71113 may incidentally burden plaintiffs because PPFA's legal structure purportedly facilitates expressive activity, that is not a basis for a First Amendment claim. Even when the particular way in which an entity is structured has "some effect" on that entity's expression, that does not mean that corporate structure itself has a "significant expressive element," as would be required for a regulation of that structure to trigger First Amendment scrutiny. *Arcara*, 478 U.S. at 706; *cf. TikTok Inc. v. Garland*, 604 U.S. 56, 68 (2025)

(observing that the challengers had not "identified any case in which [the Supreme Court] has treated a regulation of corporate control as a *direct* regulation of expressive activity" and declining to "break that new ground"). For instance, a major newspaper may arrange its corporate structure in a way that facilitates expression, but no one would regard a generally applicable law treating the newspaper's subsidiaries and affiliates as a single entity for tax purposes as raising any First Amendment concern. By the same token, any argument that PPFA's corporate structure has incidental benefits for expression would not provide a basis for a First Amendment challenge to Section 71113 or any of the many other federal laws that apply to regulated parties and their subsidiaries and affiliates.

The district court's belated attempt to cabin its theory that statutory references to "affiliates" violate the First Amendment only underscores that theory's untenable reach. In its order declining to enter a stay pending appeal, the court suggested that Section 71113 is constitutionally suspect because it does not expressly "define or limit the term 'affiliates,'" as Congress did in some of the many other U.S. Code provisions referring to affiliates. A579. But the court did not deny that other statutes, like the export-control ban, also extend statutory requirements to affiliates without defining that term. A579 n.1 (citing 50 U.S.C. § 4611). Nor did the court explain why an express definition of affiliates would make any difference under its constitutional theory that "Planned Parenthood Members' affiliation with each other is expressive," which suggests that the court would have enjoined Section 71113 from applying to

Planned Parenthood with or without a statutory definition. A580. To the extent that the court's stay order recognizes that "a construction of the statute is fairly possible by which the constitutional question may be avoided," that confirms that the court should have applied that interpretation "before" hastening to enjoin Section 71113 on constitutional grounds. *Perttu v. Richards*, 605 U.S. 460, 468 (2025) (alteration and quotation marks omitted).[2]

Even if the district court's First Amendment theory were correct, it would not support the relief the court entered. In its initial order, the court recognized that its theory would, at most, justify relief for the small number of Planned Parenthood members that are not prohibited entities in their own right but that may qualify as affiliates of entities that independently satisfy the statutory definition. *See* A38. In its second order, however, the court indicated that it now viewed the theory as supporting relief for "all Plaintiffs[]," A42, as well as all Planned Parenthood members.

Nowhere did the district court explain why a First Amendment concern regarding the statute's application to entities that may be affected by the affiliate provision would justify an injunction barring the statute's application to all PPFA members. "A plaintiff's remedy must be tailored to redress the plaintiff's particular

[2] It was similarly mistaken for the district court to suggest, in its stay-denial order, that Section 71113 implicates the test outlined in *United States v. O'Brien*, 391 U.S. 367 (1968). A578. That test has no application here, where the regulated conduct involves "no element of protected expression." *Arcara*, 478 U.S. at 705.

injury," *Gill v. Whitford*, 585 U.S. 48, 73 (2018), and "should be no more burdensome to the defendant than necessary to provide complete relief to the plaintiffs," *Trump v. CASA, Inc.*, 606 U.S. 831, 852 (2025) (emphasis and quotation marks omitted). The district court insisted that "[b]ecause Section 71113 applies to affiliates of an entity that provide abortion, no Member can escape the law's burden simply by ending its own abortion services." A84. That is incorrect: If Section 71113 were enjoined only as to non-abortion-providing members, they could maintain their relationships with the other, abortion-providing members, and those other members could easily "escape the law's burden simply by ending [their] own abortion services," among other potential changes to their own behavior that would put them beyond the scope of the prohibited-entity definition. A84.

3. Plaintiffs' unconstitutional-conditions and equal-protection claims are largely premised on the First Amendment theory refuted above. The district court's discussion of those claims also highlights additional reasons that they lack merit.

As to the unconstitutional-conditions claim, the district court acknowledged that Congress holds authority to "specify the activities [it] wants to subsidize" so long as it does not "seek to leverage funding to regulate speech outside the contours of the [funded] program itself." *AID*, 570 U.S. at 214-15; *see* A66. The court believed, however, that defining a prohibited entity to encompass an entity and its affiliates together is "unrelated to the scope" of the Medicaid program. A67. But Congress was not regulating the act of affiliation itself or the acts of the non-abortion-providing

affiliates in isolation. Rather, it was making funding decisions—which are indisputably within the challenged program—based on a more thorough understanding of how federal funds might directly or indirectly contribute to abortions given the fungibility of money. *See supra* pp. 23-24.

Plaintiffs' Fifth Amendment equal-protection claim is derivative of its flawed First Amendment claim, to the extent that the district court applied heightened scrutiny on the theory that the statute interferes with protected expression. The district court was also wrong to suggest that, wholly apart from the alleged burden on association, Section 71113 may not withstand rational-basis review. *See* A86-87. That suggestion underscores the court's departure from established principles and conflicts with the decision of another district court in this circuit recognizing that Section 71113 readily withstands such review. *See Family Plan.*, 2025 WL 2439209, at *1-7.

Under the "exceedingly deferential" rational-basis standard, *Family Plan.*, 2025 WL 2439209, at *1, "legislation is presumed to be valid and will be sustained if the classification drawn . . . is rationally related to a legitimate state interest," *González-Droz v. González-Colón*, 660 F.3d 1, 9 (1st Cir. 2011) (alteration in original) (quotation marks omitted). Here, Section 71113 furthers Congress's legitimate interests in ensuring that federal taxpayer dollars do not indirectly subsidize abortions and in declining to support entities engaged in a practice that many Americans find abhorrent. The district court glossed over these legitimate bases for the law and instead questioned why restricting funding only of essential community providers "is

in any way related to reducing abortion." A87. But those providers—which primarily serve low-income, medically underserved individuals—are most likely to have many Medicaid patients, therefore justifying the administrative burdens associated with identifying prohibited entities. In any event, given that the Supreme Court has rejected underinclusivity arguments "even under strict scrutiny," such arguments plainly have no purchase when rational-basis review applies. *Williams-Yulee v. Florida Bar*, 575 U.S. 433, 449 (2015).

4. The district court appropriately did not endorse plaintiffs' fallback claim that Congress enacted Section 71113 in retaliation for plaintiffs' expressive advocacy. *See* A88 (declining to reach this claim). Even if the retaliation claim were properly before this Court on appeal, *but see New Comm Wireless Servs., Inc. v. SprintCom, Inc.*, 287 F.3d 1, 13 (1st Cir. 2002) (recognizing that the Court "ordinarily will not uphold a preliminary injunction on a ground that was not fully addressed by the trial court"), that claim is meritless. As an initial matter, a longstanding "principle of constitutional law" generally bars courts from "strik[ing] down an otherwise constitutional statute on the basis of an alleged illicit legislative motive." *United States v. O'Brien*, 391 U.S. 367, 383 (1968). Regardless, plaintiffs come nowhere near demonstrating that Congress enacted Section 71113 to retaliate against Planned Parenthood for its expressive advocacy. As discussed, Section 71113 applies without regard to expression, and

plaintiffs fail to show that animus motivated even a single legislator, much less a 535-member legislative body. *See supra* pp. 17-18.

II. The Remaining Factors Confirm That Plaintiffs Are Not Entitled To An Injunction

Because plaintiffs have failed to establish a likelihood of success on the merits, the preliminary injunctions should be vacated. *See Doe v. Trustees of Bos. Coll.*, 942 F.3d 527, 536 (1st Cir. 2019) (recognizing that when a district court incorrectly identifies a likelihood of success on the merits, "the district court has abused its discretion and we are required to vacate the injunction"). The remaining factors reinforce that conclusion.

The district court's injunctions inflict serious harm on the government and the public. There is a strong "presumption of constitutionality which attaches to every Act of Congress." *Bowen v. Kendrick*, 483 U.S. 1304, 1304 (1987) (Rehnquist, C.J., in chambers) (quotation marks omitted). "Any time a [government] is enjoined by a court from effectuating statutes enacted by representatives of its people, it suffers a form of irreparable injury." *District 4 Lodge of the Int'l Ass'n of Machinists & Aerospace Workers Loc. Lodge 207 v. Raimondo*, 18 F.4th 38, 47 (1st Cir. 2021) (alteration in original) (alteration and quotation marks omitted). Thus, the Supreme Court has traditionally presumed that "all Acts of Congress . . . 'should remain in effect pending a final decision on the merits by [the Supreme] Court.'" *Turner Broad. Sys., Inc. v. FCC*, 507 U.S. 1301, 1301 (1993) (Rehnquist, C.J., in chambers).

These harms are especially serious given Section 71113's subject matter. The district court's injunctions trench on Congress's "broad discretion" under Article I of the Constitution to determine how federal taxpayer dollars are spent. *AID*, 570 U.S. at 213. And the spending determination at issue here reflects the elected Branches' adoption of a policy against allocating federal taxpayer dollars to providers of abortion—conduct that many Americans find abhorrent or otherwise do not wish to subsidize. That policy is freighted with moral and political significance, and if the injunctions blocking it are allowed to go into effect, they would inflict grave injury by "prevent[ing] the Government from enforcing its policies" in this sensitive area. *CASA*, 606 U.S. at 859.

The district court dismissed these fundamental government interests as "minimal" because "Section 71113 was enacted as part of budget reconciliation legislation" and would have only a "negligible impact on the federal budget," according to the court's own back-of-the-envelope assessment of congressional budgeting priorities. A92. But it was error for the court to treat the government's harms as a mere matter of dollars and cents. Congress implements "value judgment[s]" by means of "the allocation of public funds." *Rust*, 500 U.S. at 192-93 (citation omitted). This is a case in point: a judicial order compelling federal taxpayers to indirectly subsidize abortions notwithstanding Congress's contrary judgment would impose a substantial injury no matter the size of each individual taxpayer's forced contribution.

By contrast, plaintiffs fail to establish any irreparable harm, much less harm sufficient to justify enjoining the enforcement of an Act of Congress. The district court's belief that plaintiffs demonstrated irreparable harm in the form of a constitutional injury depended on the court's mistaken view of the merits. *See* A89-93. For the reasons given above, Section 71113 readily passes constitutional muster. *See Bowen*, 483 U.S. at 1304 (Rehnquist, C.J., in chambers) (the presumption of constitutionality "is not merely a factor to be considered in evaluating success on the merits, but an equity to be considered in favor of [the government] in balancing hardships").

Plaintiffs' desire to obtain federal funds that Congress withheld likewise provides no basis for an injunction. Any injury from lost funds is reparable, as plaintiffs could likely seek reimbursement for covered services from the states at the conclusion of this litigation if they were to prevail. *See* 42 U.S.C. § 1320b–2(a) (providing states up to two years to submit claims for services rendered to state Medicaid agencies or designated contractors); 45 C.F.R. § 95.19 (creating an exception to the two-year deadline when payments are made pursuant to a court order). And although the district court briefly suggested (A93) that plaintiffs' inability to access federal Medicaid funds may lead to "disruption in patient care and corresponding adverse health outcomes," it failed to explain why plaintiffs could not continue providing these services with other funding sources, why Medicaid patients would not be able to obtain care from healthcare providers that are not prohibited entities under

Section 71113, or why plaintiffs could not simply cease providing abortions and otherwise continue serving Medicaid patients.

CONCLUSION

For the foregoing reasons, this Court should vacate the preliminary injunctions.

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September 2025

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 8,867 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 Word for Microsoft 365 in Garamond 14-point font, a proportionally spaced typeface.

s/ Steven H. Hazel
Steven H. Hazel

CERTIFICATE OF SERVICE

I hereby certify that on September 29, 2025, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the First Circuit by using the appellate CM/ECF system. Service will be accomplished by the appellate CM/ECF system.

s/ Steven H. Hazel
Steven H. Hazel

ADDENDUM

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Reconciliation Act of 2025, Pub. L. No. 119-21, 139 Stat. 72

§ 71113. Federal Payments to Prohibited Entities

(a) IN GENERAL.—No Federal funds that are considered direct spending and provided to carry out a State plan under title XIX of the Social Security Act or a waiver of such a plan shall be used to make payments to a prohibited entity for items and services furnished during the 1-year period beginning on the date of the enactment of this Act, including any payments made directly to the prohibited entity or under a contract or other arrangement between a State and a covered organization.

(b) DEFINITIONS.—In this section:

(1) PROHIBITED ENTITY.—The term "prohibited entity" means an entity, including its affiliates, subsidiaries, successors, and clinics—

(A) that, as of the first day of the first quarter beginning after the date of enactment of this Act—

(i) is an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code;

(ii) is an essential community provider described in section 156.235 of title 45, Code of Federal Regulations (as in effect on the date of enactment of this Act), that is primarily engaged in

family planning services, reproductive health, and related medical care; and

(iii) provides for abortions, other than an abortion—

(I) if the pregnancy is the result of an act of rape or incest; or

(II) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed; and

(B) for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act for medical assistance furnished in fiscal year 2023 made directly, or by a covered organization, to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded $800,000.

(2) DIRECT SPENDING.—The term "direct spending" has the meaning given that term under section 250(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 900(c)).

(3) COVERED ORGANIZATION.—The term "covered organization" means a managed care entity (as defined in section 1932(a)(1)(B) of the Social Security Act (42 U.S.C. 1396u–2(a)(1)(B))) or a prepaid inpatient health plan or prepaid ambulatory health plan (as such terms are defined in section 1903(m)(9)(D) of such Act (42 U.S.C. 1396b(m)(9)(D))).

(4) STATE.—The term "State" has the meaning given such term in section 1101 of the Social Security Act (42 U.S.C. 1301).

(c) IMPLEMENTATION FUNDING.—For the purposes of carrying out this section, there are appropriated, out of any monies in the Treasury not otherwise appropriated, to the Administrator of the Centers for Medicare & Medicaid Services, $1,000,000 for fiscal year 2026, to remain available until expended.

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS, and PLANNED PARENTHOOD ASSOCIATION OF UTAH, Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as Secretary of the U.S. Department of Health and Human Services, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, MEHMET OZ, in his official capacity as Administrator of the Centers for Medicare & Medicaid Services, and CENTERS FOR MEDICARE & MEDICAID SERVICES, Defendants.	*	Civil Action No. 1:25-cv-11913-IT

MEMORANDUM & ORDER

July 21, 2025

TALWANI, D.J.

In this action, Plaintiffs Planned Parenthood Federation of America, Inc. ("Planned Parenthood Federation"), Planned Parenthood League of Massachusetts ("Planned Parenthood Massachusetts"), and Planned Parenthood Association of Utah ("Planned Parenthood Utah") allege that Section 71113 of An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14 ("the Reconciliation Act"), Pub. L. No. 119-21, 139 Stat. 72, 300-01 (July 4, 2025), violates the United States Constitution by subjecting Planned Parenthood Federation and its Members to a bill of attainder, retaliating against them in violation of the First Amendment, and

denying them equal protection of law. Plaintiffs assert further that the provision, which directs that certain entities may not receive federal Medicaid funds for a one-year period ("Prohibited Entities"), should not be read to apply to Planned Parenthood Members who do not independently satisfy Section 71113's requirements ("Non-Qualifying Members"),[1] and that if it is read to apply to these Members, it is unconstitutionally vague and violates Planned Parenthood Federation and these Members' First Amendment and Due Process rights.

Now before the court is Plaintiffs' Emergency Motion for a Preliminary Injunction [Doc. No. 4] seeking to preliminarily enjoin Defendants from enforcing Section 71113 against Planned Parenthood Members. Mot. [Doc. No. 4]. Defendants oppose the motion, asserting that "democratically elected components of the Federal Government collaborated to enact that provision consistent with their electoral mandates from the American people as to how they want their hard-earned taxpayer dollars spent." Defs.' Mem. 1 [Doc. No. 53]. In Defendants' view, "the law turns on action, not advocacy." Id. (emphasis in original).

Defendants' overview frames this inquiry: Is Section 71113 directed at entities solely because they provide elective abortions or also because of their advocacy? As explained below, Section 71113 burdens the exercise of Planned Parenthood Federation and its Members' First Amendment right of association and is thus subject to strict scrutiny review. Under that standard, Plaintiffs have demonstrated a substantial likelihood of success on Plaintiffs' First Amendment claim on behalf of those Members who do not provide elective abortions and on all Plaintiffs'

[1] The parties use this term in their briefing to describe Planned Parenthood Members that do not independently meet Section 71113's definition of "prohibited entity." See Pls.' Mem. 14 [Doc. No. 5]; Defs.' Mem. 6 [Doc. No. 53].

equal protection claim based on the burdening of their right of association, where the law's classifications are not sufficiently tailored to stop elective abortions rather than advocacy.

The court finds further that Planned Parenthood Federation, on its own behalf and on behalf of Non-Qualifying Members, including Planned Parenthood Utah, satisfy the remaining requirements to obtain a preliminary injunction.

Accordingly, Plaintiffs' Emergency Motion for Preliminary Injunction [Doc. No. 4] is GRANTED in part, as set forth below, and otherwise remains under advisement.

I. Factual Background

The factual record before the court at the preliminary injunction stage as to the counts addressed here is as follows:

A. *Medicaid*

Medicaid is a joint state-federal funding program for medical assistance established by Title XIX of the Social Security Amendments of 1965. See Social Security Amendments of 1965, Pub. L. No. 89-97, § 121, 79 Stat. 286, 343–44 (1965); see also Costello Decl. ¶ 2 [Doc. No. 53-1] ("Medicaid is a joint state/federal partnership"). "Congress created Medicaid in 1965 to subsidize state efforts to provide healthcare to families and individuals 'whose income and resources are insufficient to meet the costs of necessary medical services.'" Medina v. Planned Parenthood South Atlantic, 606 U.S. __, 145 S. Ct. 2219, 2226 (2025) (quoting Armstrong v. Exceptional Child Center, Inc., 575 U.S. 320, 323 (2015) (quoting 42 U.S.C. § 1396-1)). States are not required to participate in Medicaid, but all states and the District of Columbia currently participate. Brindis Decl. ¶ 15 [Doc. No. 5-5].

Medicaid is the largest source of health coverage in the United States. Id. ¶ 14. Medicaid is administered at the State level, but the majority of Medicaid funding is provided by the federal government in every state. Custer Decl. ¶ 41 [Doc. No. 5-1]; Brindis Decl. ¶ 15 [Doc. No. 5-5];

see also Medina, 145 S. Ct. at 2226 ("Historically, the federal government has provided on average about 57% of the funds required to implement Medicaid, and States have supplied the balance.") (citing Congressional Research Service, Medicaid: An Overview 21 (2025)).

Under Title XIX, Congress has authorized annual appropriations for each fiscal year in "a sum sufficient" to carry out the purposes of the program, which "shall be used" for making payments to participating States. 42 U.S.C. § 1396-1. Medicaid is categorized as "mandatory spending" or "direct spending." Medicaid Financing and Expenditures, https://www.congress.gov/crs-product/R42640 (last accessed July 21, 2025). For the fiscal year ending September 30, 2025, Congress has appropriated $406,956,850,000 for grants to State Medicaid programs. Full-Year Continuing Appropriations and Extensions Act, 2025, Pub. L. No. 119-4 § 1101(a)(8), (c), 139 Stat. 9, 10–11 (Mar. 15, 2025) (appropriating amount provided in Further Consolidated Appropriations Act, Pub. L. No. 118-47, 138 Stat. 662 (2024)). Congress has appropriated an additional $261,063,820,000 for Medicaid for the first quarter of fiscal year 2026. Id. § 1109(b).

Each state that chooses to participate in Medicaid must submit a plan to the Secretary of Health and Human Services ("HHS") for approval. See 42 U.S.C. § 1396a(a), (b). The Secretary exercises authority to administer the Medicaid program through the Centers for Medicare and Medicaid Services ("CMS"). If a State's plan is approved, the State is entitled to Medicaid funds from the federal government for a percentage of the money it spends in providing covered medical care to eligible individuals. 42 U.S.C. § 1396b(a)(1); see also Arkansas Dep't of Health & Hum. Servs. v. Ahlborn, 547 U.S. 268, 275 (2006) (describing the Medicaid program). Federal law requires participating States to cover certain groups of individuals. See Medicaid, List of Medicaid Eligibility Groups, Mandatory Categorically Needy,

https://www.medicaid.gov/medicaid/eligibility/downloads/list-of-eligibility-groups.pdf (last visited July 21, 2025). If a patient is entitled to receive benefits under the program's criteria, that patient may enroll and receive health care services from Medicaid providers. Brindis Decl. ¶ 18 [Doc. No. 5-5].

Medicaid generally works through reimbursement; the program reimburses healthcare providers for covered services that they have delivered to patients. Costello Decl. ¶ 19 [Doc. No. 53-1]. CMS does not directly pay Medicaid providers. Id. ¶ 7. Instead, Medicaid provider payment occurs at the state level. Id. CMS issues advanced funding for State Medicaid programs through initial grant awards to States at the beginning of each quarter based on CMS-reviewed state expenditure estimates. Id. ¶ 3. Once CMS approves the advanced funding request, the State can draw down the federal advance for the allotted amount as costs are incurred. Id. ¶ 4 (citing 42 C.F.R. § 430.30(d)(3)). Every quarter, initial awards are reconciled to actual state expenditures following a finalization process that includes quarterly CMS reviews of state-submitted, actual expenditures and state draw-downs. Id. ¶ 5.

Congress has long prohibited the use of any federal funds to reimburse the cost of abortions under the Medicaid program except in limited circumstances. See Harris v. McRae, 448 U.S. 297, 302–03 (1980). At the same time, family planning services and supplies are a mandatory Medicaid benefit in accordance with Section 1905(a)(4)(C) of the Social Security Act. Costello Decl. ¶ 8 [Doc. No. 53-1].

B. *Plaintiffs' Organization, Mission, and Services*

1. Planned Parenthood Federation

Plaintiff Planned Parenthood Federation is a not-for-profit corporation organized under the laws of New York. Custer Decl. ¶ 7 [Doc. No. 5-1]. It is a national membership organization

with 47 Members (the "Planned Parenthood Members"), including Planned Parenthood Massachusetts and Planned Parenthood Utah. Id. Planned Parenthood Federation is not itself a healthcare provider and does not participate in Medicaid, but it supports its 47 Members, who do provide healthcare and receive Medicaid funding. Id. ¶¶ 7–8.

Planned Parenthood Federation administers accreditation standards for Planned Parenthood Members, promulgates shared medical standards and guidelines, and leads certain shared policy and program initiatives. Id. ¶ 13. Planned Parenthood Federation provides support, leadership, and guidance to Planned Parenthood Members. Id.

2. Planned Parenthood Members

Each Planned Parenthood Member is an independent non-profit organization that is incorporated and governed separately from other Members. Custer Decl. ¶ 9 [Doc. No. 5-1]; Lee Decl. ¶ 10 [Doc. No. 5-2] (Planned Parenthood Massachusetts); Ghorbani Decl. ¶¶ 1, 8–9 [Doc. No. 5-3] (Planned Parenthood Utah). Each Member has its own CEO, governance structure, staff, books, and operations. Custer Decl. ¶ 9 [Doc. No. 5-1]; Lee Decl. ¶ 10 [Doc. No. 5-2]; Ghorbani Decl. ¶ 9 [Doc. No. 5-3].

Planned Parenthood Members must agree to meet membership standards, which are outlined in Planned Parenthood Federation's bylaws and set by the Planned Parenthood Members. Custer Decl. ¶ 11 [Doc. No. 5-1]. Planned Parenthood Members elect Planned Parenthood Federation's board of directors, approve changes to Planned Parenthood Federation's bylaws and membership standards, approve Planned Parenthood Federation's long-range goals, and determine the amount each Planned Parenthood Member pays in annual dues to Planned Parenthood Federation. Id. ¶ 10.

Planned Parenthood Members provide medical services through nearly 600 health centers in 47 states and the District of Columbia and have a telehealth presence in all 50 states. Id. ¶¶ 7, 21. Each Planned Parenthood Member provides healthcare and education services in a distinct geographic area. Id. ¶ 9.

Collectively, Planned Parenthood Members provide sexual and reproductive healthcare to more people in the United States than any other provider. Id. ¶ 21. An estimated one out of every three women and one in ten men nationally has received care from a Planned Parenthood Member at least once in their lifetime, and this number is even higher among individuals with Medicaid, 43% of whom have received services from a Member health center. Id. In federal fiscal year 2023, Members served more than 2 million patients and provided approximately 9.4 million services. Id. ¶ 23.

Planned Parenthood Members offer various services depending on the needs of their communities. Id. ¶ 22. However, typical services include providing contraception (including long-acting reversible contraceptives), contraceptive counseling, physical exams, cancer screening, hormone therapy, testing and treatment for sexually transmitted infections ("STIs"), pregnancy testing and counseling, vasectomies, and colposcopies. Id. Members also provide abortion where it is legal. Id. Abortions comprise approximately 4% of Planned Parenthood Members' services nationwide. Id. ¶ 23.

Planned Parenthood Massachusetts provides services including contraception, cervical screenings, breast cancer exams, and STI tests. Lee Decl. ¶¶ 30–31 [Doc. No. 5-2]. Planned Parenthood Massachusetts provides abortion services to patients who choose to terminate a pregnancy, but no federal funds under the Medicaid program are used to reimburse Planned Parenthood Massachusetts for the cost of providing those services (except under the limited

circumstances permitted by federal law). Id. ¶ 26. Planned Parenthood Utah provides for contraception, cervical screenings, breast cancer exams, testicular cancer screening, STI tests, pregnancy testing, and abortions. Ghorbani Decl. ¶ 11 [Doc. No. 5-3]. No federal funds are used to reimburse abortion services (except under the limited circumstances permitted by federal law). Custer Decl. ¶ 45 [Doc. No. 5-1]. The remaining Planned Parenthood Members similarly receive no reimbursement for abortions from Medicaid funds or other federal funds except in permitted circumstances. Id. ¶ 45; Lee Decl. ¶ 26 [Doc. No. 5-2].

Planned Parenthood Members participate in Medicaid programs for services other than elective abortions in every state where they are able. Custer Decl. ¶ 43 [Doc. No. 5-1]. Planned Parenthood Massachusetts received $4,744,699.47 in Medicaid reimbursements during fiscal year 2023. Lee Decl. ¶ 29 [Doc. No. 5-2]. Medicaid reimbursements accounted for more than one third of Planned Parenthood Members' aggregate revenue in fiscal year 2023. Custer Decl. ¶ 44 [Doc. No. 5-1]. Some individual Members received over three quarters of their health services revenue from Medicaid reimbursement that year. Id. Approximately 51% of Planned Parenthood Members' patients rely on Medicaid for their healthcare, and half of visits to Planned Parenthood Member health centers are covered by Medicaid. Id. ¶ 43.

Planned Parenthood Massachusetts provided services to approximately 10,822 patients enrolled in Medicaid in 2024. Lee Decl. ¶¶ 30–31 [Doc. No. 5-2]. Planned Parenthood Utah provided service to approximately 2,096 patients enrolled in Medicaid in 2024. Ghorbani Decl. ¶ 24.

Some Planned Parenthood Members, including Planned Parenthood Utah and Planned Parenthood of Delaware, received less than $800,000 in Medicaid reimbursements during federal fiscal year 2023. Custer Decl. ¶¶ 63–64 [Doc. No. 5-1]; Ghorbani Decl. ¶ 20 [Doc. No. 5-3]; see

also id. ¶ 24 (Planned Parenthood Utah received $706,251.02 in Medicaid reimbursements during fiscal year 2023).

Three Planned Parenthood Members—Gulf Coast, Planned Parenthood Greater Texas, and Planned Parenthood of Tennessee and North Mississippi—do not provide abortions because abortion is not legal in any state where their health centers are located. Custer Decl. ¶ 63 [Doc. No. 5-1].

3. Plaintiffs' Mission and Advocacy

Planned Parenthood Federation's mission is to ensure that people receive high-quality, inclusive, and comprehensive sexual and reproductive healthcare regardless of income, insurance, gender identity, sexual orientation, or race; to provide related educational services; to promote research on sexual and reproductive health; and to advocate for public policies that guarantee access to such services. Custer Decl. ¶¶ 7, 12 [Doc. No. 5-1]. Planned Parenthood Members share Planned Parenthood Federation's mission. Id. ¶ 12. Planned Parenthood Federation membership is important to Planned Parenthood Members' ability to fulfill their missions. Id. ¶ 15. Planned Parenthood Federation licenses the use of the Planned Parenthood name to each Planned Parenthood Member, and the Planned Parenthood name sends a message to the community that the Planned Parenthood Member stands for certain values and provides healthcare and educational services in furtherance of the shared Planned Parenthood mission. Id. ¶¶ 14–15. Working in furtherance of that mission, Planned Parenthood Members advocate for equitable access to the sexual and reproductive healthcare, including abortion, that Members and other non-profit sexual and reproductive healthcare providers offer. Id. ¶ 19.

Planned Parenthood Federation and Planned Parenthood Members advocate at the federal, state, and local levels to protect and expand access to reproductive healthcare services

and information. Id. ¶ 75. Planned Parenthood Federation has advocated before Congress to codify the rights to abortion and contraception, block abortion bans, and repeal federal law that prohibits federal funding of abortion. Id. Planned Parenthood Federation has also advocated for access to emergency contraception and medication abortion. Id. Planned Parenthood Members, and sometimes Planned Parenthood Federation, have litigated to secure abortion access and rights for their patients in federal and state courts. Id.

Planned Parenthood Action Fund, a related 501(c)(4) organization, advocates for policies that protect care for Planned Parenthood Members' patients and publishes a "congressional scorecard" to communicate with the public regarding their lawmakers' records and to activate constituents. Id. Additionally, Planned Parenthood Action Fund has supported campaigns for ballot initiatives. Id. Separately, Planned Parenthood Action Fund works with other national and local advocacy and political organizations to elect federal, state, and local officials who will support reproductive freedom. Id. Each Planned Parenthood Member may also have a related 501(c)(4) tax-exempt entity that works in furtherance of the Planned Parenthood mission through education, advocacy, and limited electoral activities. Id. ¶ 19.

C. *Section 71113*

Section 71113(a) of the Reconciliation Act provides that "no Federal funds that are considered direct spending[2] and provided to carry out a State plan under title XIX of the Social Security Act or a waiver of such a plan shall be used to make payments to a prohibited entity for items and services furnished during the 1-year period beginning on the date of the enactment of

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[2] "Direct Spending" is defined with reference to 2 U.S.C. § 900(c)(8), which states that "[t]he term 'direct spending' means (A) budget authority provided by law other than appropriation Acts; (B) entitlement authority; and (C) the Supplemental Nutrition Assistance Program." Id. § 71113(b)(2)

this Act . . . ." Pub. L. No. 119-21, § 71113(a), 139 Stat. 72, 300-01 (July 4, 2025). Section 71113(b)(1) defines the term "prohibited entity" as:

> an entity, including its affiliates, subsidiaries, successors, and clinics--
>
> (A) that, as of the first day of the first quarter beginning after the date of enactment of this Act-
>
> (i) is an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code;
>
> (ii) is an essential community provider described in section 156.235 of title 45, Code of Federal Regulations (as in effect on the date of enactment of this Act), that is primarily engaged in family planning services, reproductive health, and related medical care; and
>
> (iii) provides for abortions, other than an abortion-
>
> (I) if the pregnancy is the result of an act of rape or incest; or
>
> (II) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed; and
>
> (B) for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act for medical assistance furnished in fiscal year 2023 made directly, or by a covered organization, to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded $800,000.

Id. § 71113(b)(1) (emphasis added).

Section 71113(c) also provides for $1,000,000 in appropriations to the Administrator of CMS for implementation. Id. § 71113(c).

D. *Prohibited and Non-Qualifying Entities Under Section 71113*

Planned Parenthood Members are non-profit entities and essential community providers who primarily engage in family planning services, reproductive health, and related medical care. See Lee Decl. ¶ 8 [Doc. No. 5-2]; Ghorbani Decl. ¶ 8 [Doc. No. 5-3]; Tosh Decl. ¶ 16 [Doc. No.

5-4]. Many Planned Parenthood Members, including Plaintiff Planned Parenthood Massachusetts, also provide abortion services and received more than $800,000 in Medicaid reimbursements for non-abortion services in fiscal year 2023, and are thus "prohibited entities" under Section 71113. See Custer Decl. ¶ 47 [Doc. No. 5-1]; Lee Decl. ¶ 29 [Doc. No. 5-2]. The Center for Medicaid and CHIP Services ("CMCS") has "identified at least two non-Planned Parenthood entities" that have provided for elective abortions and otherwise meet the definition of "prohibited entity." Snyder Decl. ¶ 6 [Doc. No. 53-2].

Other types of providers, including community health centers ("CHCs") and federally qualified health centers ("FQHCs"), also use Medicaid programs to provide healthcare services to patients. Brindis Decl. ¶ 20 [Doc. No. 5-5]. However, unlike Planned Parenthood Members, CHCs and FQHCs usually do not specialize in family planning, instead providing services such as primary care, dental care, and/or mental health care. Id. Accordingly, even if they do perform elective abortions, Section 71113 does not prohibit them from receiving Medicaid reimbursements for other services.

Ten Planned Parenthood Members (the "Non-Qualifying Members") either do not offer abortion services or did not receive $800,000 in Medicaid reimbursement. Defendants contend that "CMS . . . has had no opportunity to analyze the legal and factual questions that it must consider to construe and apply the statute[,]" and has given no "concrete indication that the Government will conclude that the 'non-qualifying members' are covered by Section 71113[.]" Defs.' Mem. 24 [Doc. No. 53]. Defendants contend alternatively that "HHS and CMS could—depending on facts which have yet to be developed—permissibly construe the statute to cover 'non-qualifying members' if, on October 1, they are 'affiliates' of members that provide for abortions." Id. at 27.

E. *Section 71113's Harm to Members and Patients*

If Planned Parenthood Members are barred from receiving federal Medicaid reimbursement for their non-abortion services, Planned Parenthood Members across the country anticipate reducing the hours and programs they offer, terminating staff members, and eventually closing health centers. See Custer Decl. ¶¶ 4, 54–57 [Doc. No. 5-1]; Lee Decl. ¶¶ 40–42 [Doc. No. 5-2]; Ghorbani Decl. ¶¶ 6, 24 [Doc. No. 5-3]; Tosh Decl. ¶¶ 45–48 [Doc. No. 5-4]. Health centers that close may never reopen. Id. ¶¶ 45–48.

A contraction in services causes a corresponding disruption to patient healthcare. See Custer Decl. ¶ 54 [Doc. No. 5-1]. Section 71113 creates an immediate disruption for over one million family planning patients who previously received care at Member health centers. Brindis Decl. ¶ 35 [Doc. No. 5-5]. The law "is already . . . forcing some Members to turn away patients enrolled in Medicaid; to attempt to refer them to other providers; or to offer Medicaid patients (who, by criteria of the program, have low incomes) the option to pay out-of-pocket for services where state law allows." Custer Decl. ¶ 49 [Doc. No. 5-1].

Planned Parenthood Massachusetts had nearly 150 scheduled appointments for Medicaid patients at their health centers on July 7 and July 8, and began informing those patients when Section 71113 was enacted that they could not use their Medicaid coverage for services at Planned Parenthood Massachusetts healthcare centers. Lee Decl. ¶ 4 [Doc. No. 5-2]. Many of those patients cannot afford to pay for care and cannot get timely care at another provider that accepts Medicaid. Id.

The law also disrupts healthcare for patients who do not rely on Medicaid. Custer Decl. ¶ 54 [Doc. No. 5-1]. Patients who can still access care at Member health centers could experience delays in receiving care. Id. ¶¶ 51, 54. Patients who seek healthcare elsewhere could

also face delays at those facilities, id. ¶ 56, and alternative providers may not be able to ramp up services quickly enough to fill the gap, Brindis Decl. ¶¶ 36–39 [Doc. No. 5-5]. Further, many Member health centers are located in medically underserved areas, primary care health professional shortage areas, and rural areas. Custer Decl. ¶ 55 [Doc. No. 5-1]. In many cases, patients who receive care at Planned Parenthood Member health centers will have no feasible alternative reproductive healthcare provider in their communities because of provider scarcity, language issues, unavailable services, or caps on Medicaid patients. Id. ¶¶ 24–29, 53–56; Lee Decl. ¶¶ 36–38 [Doc. No. 5-2]; Tosh Decl. ¶¶ 51–52, 54 [Doc. No. 5-4].

Patients are likely to suffer adverse health consequences where care is disrupted or unavailable. In particular, restricting Members' ability to provide healthcare services threatens an increase in unintended pregnancies and attendant complications because of reduced access to effective contraceptives, and an increase in undiagnosed and untreated STIs. Brindis Decl. ¶¶ 11, 58, 62–66 [Doc. No. 5-5]. Moreover, decreased access to contraceptives and the corresponding increase in the number of unintended pregnancies caused by excluding Planned Parenthood Members from Medicaid will likely result in an increased number of abortions. Id. ¶ 71. Restricting access to Member healthcare clinics will negatively affect more than just reproductive health; Members often serve as a source of primary care for patients. Id. ¶ 82. Planned Parenthood Federation reported in its most recent annual reort that its Members provided 426,268 cancer screenings and other diagnostic procedures. Id. ¶ 84. Reduced access to screening services creates a likelihood that health issues will go undetected with attendant serious consequences. Id. ¶ 74.

II. Standard of Review

The issuance of a preliminary injunction before a trial on the merits can be held is an "extraordinary remedy" that shall enter only if a plaintiff makes a clear showing of entitlement to

such relief. Winter v. Nat. Res. Def. Council, Inc., 555 U.S. 7, 22 (2008). The purpose of a preliminary injunction is "merely to preserve the relative positions of the parties until a trial on the merits can be held." Starbucks Corp. v. McKinney, 602 U.S. 339, 346 (2024) (quoting Univ. of Texas v. Camenisch, 451 U.S. 390, 395 (1981)). In evaluating a motion for a preliminary injunction, the court considers four factors:

> (1) the likelihood of success on the merits; (2) the potential for irreparable harm [to the movants] if the injunction is denied; (3) the balance of relevant impositions, i.e., the hardship to the nonmovant if enjoined as contrasted with the hardship to the movant if no injunction issues; and (4) the effect (if any) of the court's ruling on the public interest.

Esso Standard Oil Co. v. Monroig-Zayas, 445 F.3d 13, 17–18 (1st Cir. 2006) (quoting Bl(a)ck Tea Soc'y v. City of Boston, 378 F.3d 8, 11 (1st Cir. 2004)). The balancing of hardships and the analysis of the public interest merge when, as here, the government is the opposing party. Does 1–6 v. Mills, 16 F.4th 20, 37 (1st Cir. 2021) (citing Nken v. Holder, 556 U.S. 418, 435 (2009)).

The first factor is the most important: if the moving party cannot demonstrate a likelihood of success on the merits, "the remaining factors become matters of idle curiosity." New Comm Wireless Servs., Inc. v. SprintCom, Inc., 287 F.3d 1, 9 (1st Cir. 2002) (citing Weaver v. Henderson, 984 F.2d 11, 12 (1st Cir. 1993)). "To demonstrate likelihood of success on the merits, plaintiffs must show 'more than mere possibility' of success—rather, they must establish a 'strong likelihood' that they will ultimately prevail." Sindicato Puertorriqueño de Trabajadores v. Fortuño, 699 F.3d 1, 10 (1st Cir. 2012) (quoting Respect Maine PAC v. McKee, 622 F.3d 13, 15 (1st Cir. 2010)).

III. Discussion

A. *Likelihood of Success on the Merits*

1. First Amendment Rights of Members That Do Not Provide Abortions

Plaintiffs argue that if Section 71113 covers Planned Parenthood Members that do not provide abortions, the law imposes an unconstitutional condition on those Members and Planned Parenthood Federation's First Amendment right of association. Pls.' Mem. 35 [Doc. No. 5].[3] Defendants argue that Section 71113 merely "withholds funding based on whether entities provide abortion services," that Plaintiffs' arguments concerning "affiliates" are not ripe, and that "the word 'affiliate' here has nothing to do with expressive association." Defs.' Mem. 30, 33 [Doc. No. 53].

Planned Parenthood Federation and each Planned Parenthood Member are entitled to First Amendment protections. See Citizens United v. Fed. Election Comm'n, 558 U.S. 310, 355 (2010) (invalidating law on First Amendment grounds where "[t]he purpose and effect of [the] law is to prevent corporations, including . . . nonprofit corporations, from presenting both facts and opinions to the public"). "At the heart of the First Amendment lies the principle that each person should decide for himself or herself the ideas and beliefs deserving of expression, consideration, and adherence." Agency for Int'l Dev. v. All. for Open Soc'y Int'l, Inc., 570 U.S. 205, 213 (2013) (quoting Turner Broadcasting System, Inc. v. FCC, 512 U.S. 622, 641 (1994)). The Supreme Court has "long understood as implicit in the right to engage in activities protected

[3] Plaintiffs also claim that if Section 71113 covers Planned Parenthood Members who perform abortions but received less than $800,000 from Medicaid in fiscal year 2023, the law imposes an unconstitutional condition on these Members and Planned Parenthood Federation's right of association. Id. The court addresses this argument in connection with Plaintiffs' equal protection claim.

by the First Amendment a corresponding right to associate with others" in pursuit of desired political, educational, or social ends. Roberts v. U.S. Jaycees, 468 U.S. 609, 622 (1984).

At the same time, the Constitution provides Congress exclusive power "[t]o lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States." U.S. const. art. I, § 8, cl. 1. This provision gives Congress broad discretion to spend for the "general [w]elfare." All. for Open Soc'y, 570 U.S. at 213. Congress may exercise this power by funding particular programs or activities, and it has "authority to impose limits on the use of such funds to ensure they are used in the manner Congress intends." Id. "The Government can, without violating the Constitution, selectively fund a program to encourage certain activities it believes to be in the public interest, without at the same time funding an alternative program which seeks to deal with the problem in another way." Rust v. Sullivan, 500 U.S. 173, 193 (1991). Generally, a party is limited to declining federal funds where it objects to a condition Congress places on receipt of those funds, even where that condition affects the recipient's First Amendment rights. All. for Open Soc'y, 570 U.S. at 214.

However, "the unconstitutional conditions doctrine forbids burdening the Constitution's enumerated rights by coercively withholding benefits from those who exercise them." Koontz v. St. Johns River Water Mgmt. Dist., 570 U.S. 595, 606 (2013). The government

> may not deny a benefit . . . on a basis that infringes [a recipient's] constitutionally protected interests—especially, [the recipient's] interest in freedom of speech. For if the government could deny a benefit to a [recipient] because of . . . constitutionally protected speech or associations, [the recipient's] exercise of those freedoms would in effect be penalized and inhibited. This would allow the government to "produce a result which (it) could not command directly."

Perry v. Sindermann, 408 U.S. 593, 597 (1972) (last alteration in original) (quoting Speiser v. Randall, 357 U.S. 513, 526 (1958)). The unconstitutional conditions doctrine bars the government from denying a benefit "on a basis that infringes [the recipient's] constitutionally

protected . . . freedom of speech even if [the recipient] has no entitlement to that benefit." Rumsfeld v. F. for Acad. & Institutional Rts., Inc., 547 U.S. 47, 59 (2006) (quoting United States v. American Library Ass'n., Inc., 539 U.S. 194, 210 (2003)). Permissible conditions on funding "specify the activities Congress wants to subsidize[,]" while unconstitutional conditions "seek to leverage funding to regulate speech outside the contours of the [funded] program itself." All. for Open Soc'y, 570 U.S. at 214–15.

Contrary to Defendants' assertion, Section 71113 does not merely "withhold[] funding based on whether entities provide abortion services," but also based on whether "an entity, including its affiliates," provides abortion services.[4] Pub. L. No. 119-21, § 71113(b)(1), 139 Stat. 72, 300 (July 4, 2025) (emphasis added). And Defendants assert that "two entities' existence under common control" would satisfy the dictionary definition of an "affiliate," and that, in Defendants' view, Planned Parenthood Federations' "membership standards," "accreditation standards," and "shared medical standards and guidelines," would be sufficient to show common control such that Planned Parenthood Members who do not provide abortion could be "affiliates" of the Planned Parenthood Members who do. See Defs.' Mem. 28 [Doc. No. 53].

[4] Defendants' assertion that Plaintiffs' arguments concerning the law's application to "affiliates" are not ripe fails where, without injunctive relief, Planned Parenthood Members who do not provide abortion services will need to decide whether to disaffiliate from other Planned Parenthood Members before October 1, 2025, or risk ineligibility for Medicaid reimbursements because of their continuing membership in Planned Parenthood Federation. Therefore, even accepting Defendants' contention that there is uncertainty regarding how Defendants will apply Section 71113 to "affiliates," this uncertainty has an immediate chilling effect on Members' right of association. Given this chilling effect, and in light of Defendants' ultimate contention that "HHS and CMS could permissibly conclude (. . . depending on the facts as of October 1) that [Planned Parenthood Federation] members are all 'affiliates' within the meaning of the statute," id. at 29, Plaintiffs' unconstitutional conditions claim is ripe. See Franklin California Tax-Free Tr. v. Puerto Rico, 805 F.3d 322, 333 n.16 (1st Cir. 2015) (concluding case ripe where "plaintiffs allege that the very enactment of the [statute], rather than the manner of enforcement" impaired plaintiffs' rights") (emphasis in original).

To the extent that Section 71113 may be applied to Planned Parenthood Members who do not provide abortion, Plaintiffs are likely to succeed in establishing that the law impermissibly conditions the receipt of Medicaid funding on these Members foregoing their right to associate with Planned Parenthood Federation and other Members. Members who do not provide abortions cannot escape the law's burden except by disassociating from Members that do. And because Section 71113 may be applied to Members who are affiliates of each other via the structure, governance, and membership requirements of Planned Parenthood Federation, disassociating with other Members requires disassociating from Planned Parenthood Federation itself.

While Defendants contend that Section 71113 does not regulate speech, the record demonstrates that Members' affiliation via their membership in Planned Parenthood Federation is expressive. Planned Parenthood Federation advocates before Congress, provides education and information about sexual and reproductive health, and through Planned Parenthood Action Fund, communicates with the public regarding lawmakers' voting records, supports campaigns for ballot initiatives, and supports candidates for federal, state, and local officials who will support reproductive freedom in furtherance of its mission. Custer Decl. ¶¶ 38, 75 [Doc. No. 5-1]. Members engage in those activities with Planned Parenthood Federation and each other. Id. ¶ 75. Additionally, Planned Parenthood Federation provides leadership and financial support to Members around shared policy and program initiatives. Id. ¶¶ 13, 75. Moreover, each Member licenses the use of the Planned Parenthood name, which expresses that each Member stands for particular values. Id. ¶¶ 14–15. Membership in Planned Parenthood Federation—and corresponding affiliation with other Members—is thus part and parcel with Planned Parenthood Members' associational expression.

The association between Members and with Planned Parenthood Federation is protected expression that is "outside the contours" of the Medicaid program. All. for Open Soc'y, 570 U.S. at 214–15. The "government is not required to subsidize activities that it does not wish to promote." Matal v. Tam, 582 U.S. 218, 240 (2017) (citing 570 U.S. at 215). Congress may set conditions "that define the limits" of a spending program by "specify[ing] the activities Congress wants to subsidize," but Congress may not set "conditions that seek to leverage funding to regulate speech outside the contours of the program itself." 570 U.S. at 214–15. Here, Medicaid funds healthcare services for qualifying low-income patients. Section 71113 places conditions on funds appropriated for Medicaid, including that a Medicaid provider may not affiliate with a "prohibited entity," which by definition provides abortions. But conditioning Medicaid funding on affiliation is not a limit on the services that Medicaid funds may reimburse.

Rust v. Sullivan provides an illustrative distinction. There, Congress barred project funds from funding particular conduct: abortion-related speech. 500 U.S. at 196. The regulations at issue allowed funded entities to engage in abortion-related speech so long as it was not funded with project monies. Id. In upholding Congress's limitation on funding, the Supreme Court emphasized that "'unconstitutional conditions' cases involve situations in which the Government has placed a condition on the recipient of the subsidy rather than on the program or service," which "effectively prohibit[s] the recipient from engaging in the protected conduct outside the scope of the federally funded program." Id. at 197. That is what the government has done here. Congress has refused to fund particular recipients: affiliates of entities that provide abortion. Therefore, Members that do not provide abortion must disassociate from Planned Parenthood Federation to disaffiliate from Members that provide abortion to remain eligible for Medicaid funds. This requirement is unrelated to the scope of healthcare services that a Member provides.

The Supreme Court has underscored that the use of separate corporate entities, even where closely related, allows Congress to set conditions with its spending powers without unconstitutionally leveraging the funding to regulate speech. In Regan v. Taxation With Representation of Wash., 461 U.S. 540 (1983), the Court upheld a prohibition on "substantial lobbying activities" by 501(c)(3) organizations against an unconstitutional conditions challenge in part because the organization remained free to use a "dual structure . . . , with a § 501(c)(3) organization for non-lobbying activities and a § 501(c)(4) organization for lobbying," meaning the prohibition did not necessarily inhibit the organization's ability to engage in First Amendment activities. Id. at 544–45. In F.C.C. v. League of Women Voters of Cal., 468 U.S. 364 (1984), the Court struck down a statute barring any recipient of certain federal grants from engaging in editorializing. Id. at 400. In so holding, the Court explained that "if Congress were to adopt a revised version" of the statute "that permitted . . . broadcasting stations to establish 'affiliate' organizations" that engaged in editorializing, "such a statutory mechanism would plainly be valid" because "[a] public broadcasting station[] would be free . . . to make known its views on matters of public importance through its nonfederally funded, editorializing affiliate without losing federal grants for its noneditorializing broadcast activities." Id.

Here, Section 71113 prohibits the type of dual structure that would have insulated the abortion restriction from an unconstitutional conditions challenge. Instead of merely prohibiting Planned Parenthood Members that receive Medicaid funds from providing abortions, the statute prohibits them from affiliating with entities that do. Moreover, the record is devoid of evidentiary support for Defendants' suggestion that Planned Parenthood entities share funds that are ultimately used for abortions. See Defs.' Mem. 35 [Doc. No. 53]. Therefore, restricting funds

based on affiliation with an abortion provider operates only to restrict the associational right of Members that do not provide abortion.

Defendants also rely on Lyng v. Int'l Union, United Auto., Aerospace & Agr. Implement Workers of Am., UAW, 485 U.S. 360 (1988), where the Supreme Court found denying food stamps to households of striking workers did not violate the associational rights of household members or striking workers. Id. at 366. The Court there explained that a legislature's decision "not to subsidize the exercise of a fundamental right does not infringe the right." Id. at 368 (citing Regan, 461 U.S. at 549 (1983)). But the Court also acknowledged that associational rights "can be abridged even by government actions that do not directly restrict" the "ability to associate freely," and that the right to associate is "protected not only against heavy-handed frontal attack, but also from being stifled by more subtle governmental interference." Id. at 367 n.5 (citations omitted).

Further, in Lyng, the law denied eligibility for food stamps only while a household member was on strike. Id. at 362. And in upholding the law, the court explained:

> Exposing the members of an association to . . . economic reprisals . . . merely because of their membership in that group poses a much greater danger to the exercise of associational freedoms than does the withdrawal of a government benefit based not on membership in an organization but merely for the duration of one activity that may be undertaken by that organization.

Id. at 367 n.5. Here, Section 71113 withholds Medicaid reimbursements from Planned Parenthood Members who do not provide abortion so long as any other Member continues to do so. Where Section 71113 imposes a funding restriction based on the activity of other Members, the law burdens membership in Planned Parenthood Federation rather than a particular activity in which a Member engages. And the government may not burden a Member's associational right as a means of limiting other Members' undesired conduct. See NAACP v. Claiborne Hardware Co., 458 U.S. 886, 908 (1982) ("[T]he right to associate does not lose all constitutional

protection merely because some members of the group may have participated in conduct . . . that itself is not protected.").

In sum, where Section 71113 disqualifies Planned Parenthood Members who do not provide abortion because of their affiliation with other Members who will continue to provide abortion, and where membership in Planned Parenthood Federation is expressive, Plaintiffs are likely to succeed in establishing that Section 71113 unconstitutionally conditions Medicaid funding on these Members foregoing their First Amendment right of association.

2. Equal Protection

Plaintiffs assert that Section 71113 violates the Fifth Amendment's equal protection guarantee by barring Planned Parenthood Members from receiving Medicaid funding while "leaving virtually all other abortion providers outside its scope." Pls.' Reply 1 [Doc. No. 60]. Plaintiffs argue that Section 71113 is subject to strict scrutiny because it treats Planned Parenthood Members differently than other similarly-situated entities because of their association with Planned Parenthood Federation and each other. Pls.' Mem. 24–25 [Doc. No. 5]. And Plaintiffs argue that the law fails strict scrutiny because it applies based on a combination of conjunctive criteria that almost exclusively affect Planned Parenthood Members, Pls.' Reply 1 [Doc. No. 60], and are unrelated to the goal of reducing abortions. Pls.' Mem. 25 [Doc. No. 5]. Defendants respond that rational basis review applies and that the law effectuates a congressional desire "to reduce abortion and government subsidization of abortions." Defs.' Mem. 23 [Doc. No. 53].

a. Framework

"[T]he Due Process Clause of the Fifth Amendment forbids the Federal Government to deny equal protection of the laws." Vance v. Bradley, 440 U.S. 93, 94 n.1 (1979) (collecting

cases). Equal protection claims under the Fifth Amendment are subject to the same analysis as 14th Amendment equal protection claims. Weinberger v. Wiesenfeld, 420 U.S. 636, 638 n.2 (1975).

Equal protection directs "that all persons similarly situated should be treated alike." City of Cleburne, Tex. v. Cleburne Living Ctr., 473 U.S. 432, 439 (1985); see also Walker v. Exeter Region Co-op. Sch. Dist., 284 F.3d 42, 44 n.2 (1st Cir. 2002) ("[T]he equal protection guaranteed by the Constitution forbids the legislature to select a person, natural or artificial, and impose upon him or it burdens and liabilities which are not cast upon others similarly situated.") (quoting Atchison, Topeka & Santa Fe R.R. Co. v. Matthews, 174 U.S. 96, 104 (1899)). Entities are similarly situated where "a prudent person, looking objectively at the incidents, would think them roughly equivalent and the protagonists similarly situated." Barrington Cove Ltd. P'ship v. R.I. Hous. & Mortg. Fin. Corp., 246 F.3d 1, 8 (1st Cir. 2001) (citation omitted).

"The Constitution does not require things which are different in fact or opinion to be treated in law as though they were the same." Plyler v. Doe, 457 U.S. 202, 216 (1982) (quoting Tigner v. Texas, 310 U.S. 141, 147 (1940)). And a legislature "ha[s] substantial latitude to establish classifications that roughly approximate the nature of the problem perceived[.]" Id. Accordingly, legislative classifications are generally permissible so long as "the classification at issue bears some fair relationship to a legitimate public purpose." Id. "[A] statutory classification that neither proceeds along suspect lines nor infringes fundamental constitutional rights must be upheld against equal protection challenge if there is any reasonably conceivable state of facts that could provide a rational basis for the classification." F.C.C. v. Beach Commc'ns, Inc., 508 U.S. 307, 313 (1993). "[C]lassifications that . . . impinge upon the exercise of a 'fundamental right'" are "presumptively invidious." Plyler, 457 U.S. at 216–17. Impingement of these fundamental

rights, including "free speech rights, are subject to strict scrutiny and will only be upheld if 'precisely tailored to serve a compelling governmental interest.'" Rocket Learning, Inc. v. Rivera-Sanchez, 715 F.3d 1, 9 n.6 (1st Cir. 2013) (quoting Plyler, 457 U.S. at 217). In such cases, the government bears the burden to demonstrate "that its classification has been precisely tailored to serve a compelling governmental interest." Plyler, 457 U.S. at 216–17.

b. Discussion

Section 71113 bars a narrow class of healthcare providers from receiving Medicaid funding. As relevant here, Section 71113 denies Medicaid funds to non-profit health care providers that are "essential community provider[s] . . . primarily engaged in family planning services, reproductive health, and related medical care"[5] and provide abortion. See Pub. L. No. 119-21, § 71113(b)(1)(A), 139 Stat. 72, 300 (July 4, 2025). Additionally, a Planned Parenthood Member that provides abortion services but did not exceed $800,000 in Medicaid funding in fiscal year 2023 may be precluded from receiving Medicaid funding as an "affiliate" of another Member that provides abortion services that meets the funding threshold.

These conjunctive criteria capture a small subset of abortion providers while leaving many others untouched. For-profit abortion providers may still receive Medicaid reimbursements for covered non-abortion services. Entities that provide abortions but are not "essential community providers" because they do not primarily serve predominantly low-income,

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[5] As defined by 45 C.F.R. § 156.235(c),

> [a]n essential community provider is a provider that serves predominantly low-income, medically underserved individuals . . . ; or a State-owned family planning service site, or governmental family planning service site, or not-for-profit family planning service site that does not receive Federal funding under special programs, including under Title X of the PHS Act, or an Indian health care provider . . . .

medically underserved individuals may still engage in family planning services without losing Medicaid funding. Entities that provide abortions, are "essential community providers," but are not primarily engaged in family planning services, such as community health centers and federally qualified health centers, see Brindis Decl. ¶ 20 [Doc. No. 5-5], may also still receive Medicaid payments for their non-abortion services. And Section 71113 does not cover any abortion provider that did not receive more than $800,000 in Medicaid funding in fiscal year 2023 that is not an "affiliate" of an entity that meets the definition of "prohibited entity." On the record before the court, Section 71113 applies to 46 abortion providers: 37 Planned Parenthood Members that meet all of the "prohibited entity" criteria, 7 Planned Parenthood Members who provide abortion but received less than $800,000 in Medicaid reimbursements in fiscal year 2023 but may be considered "affiliated" with Planned Parenthood Members, see Custer Decl. ¶ 63 [Doc. No. 5-1], and two non-Planned Parenthood entities. See Snyder Decl. ¶ 6 [Doc. No. 53-2].

But where Section 71113 classifies on the basis of affiliation, it impinges on Planned Parenthood Federation's and each Members' right of association. Because Section 71113 applies to affiliates of an entity that provide abortion, no Member can escape the law's burden simply by ending its own abortion services. Instead, a Member must also disaffiliate from any Member that continues to provide abortion, which requires disassociating from Planned Parenthood Federation. As explained above, conditioning Medicaid funding on disassociating from Planned Parenthood Federation burdens the right of association. Because Section 71113 impinges on a fundamental right, it is subject to strict scrutiny. See Rocket Learning, 715 F.3d at 9 n.6.

Defendants argue first that this classification is constitutionally permissible because Congress is "free to decline to provide taxpayer funds to entities that provide abortions." Defs.' Mem. 21 [Doc. No. 53]; see also id. at 14 ("Congress may make a policy choice not to contract

with abortion providers even for covered medical care"). But Section 71113 is not "precisely tailored" toward denying taxpayer funds from abortion providers where Defendants do not dispute that the conjunctive criteria leave "virtually all abortion providers who participate in Medicaid—other than Planned Parenthood Members—unaffected" by the legislation. Pls.' Mem. 25 [Doc. No. 5] (emphasis in original).

Defendants argue further that Congress was free to focus on providers that are "primarily engaged in family planning services, reproductive health, and related medical care" because "they are likely to perform a higher proportion of abortions," and was free to distinguish between for-profit providers and non-profit providers because the non-profits already receive "an implicit government subsidy (in the form of tax-exempt status)[.]" Defs.' Mem. 22 [Doc. No. 53]. But Defendants do not explain how excluding providers of family planning services, reproductive healthcare, and related medical care that are not "essential community providers" because they do not serve predominantly low-income or medically underserved individuals relates to Congress's goal of reducing abortion. Nor do Defendants explain how denying funding from entities that already have "the benefit of a tax-exempt status" furthers that end.

Defendants also assert that Congress was free to address providers that specialize in family planning and received more than $800,000 in Medicaid funding in fiscal year 2023 because "[l]arger providers carry out more abortions and receive more government subsidies, so they are a natural first target." Id. at 22. But Defendants offer no basis for treating Planned Parenthood members who provide abortion but received less than $800,000 in Medicaid reimbursement, such as Planned Parenthood Utah, differently than other abortion providers who received less than $800,000 and are not Planned Parenthood Members. Congress sought to treat Planned Parenthood Federation and its Members as a single legal entity. See id. at 1 ("[T]he bill

stops federal subsidies for Big Abortion."). But the record before the court establishes each Planned Parenthood Member is an independent organization. See Custer Decl. ¶ 9 [Doc. No. 5-1]. Consequently, restricting funding for them on the basis of affiliation creates the First Amendment problem described above.

At bottom, Defendants seek to justify each of Section 71113's criteria in isolation, but offer no justification for the classification established by the criteria in conjunction. Defendants argue that this classification is constitutionally permissible because Congress is "free to decline to provide taxpayer funds to entities that provide abortions." Defs.' Mem. 21 [Doc. No. 53]; see also id. at 14 ("Congress may make a policy choice not to contract with abortion providers even for covered medical care."). But Section 71113 does more: It declines Medicaid funding on the basis of affiliation, and thus draws a classification that burdens a fundamental First Amendment right. Where Defendants have not shown the law is precisely tailored to serve a compelling governmental interest, Plaintiffs have demonstrated a substantial likelihood of success on their equal protection claim.

B. *Irreparable Harm to Planned Parenthood Federation and the Non-Qualifying Members*

"'Irreparable injury' in the preliminary injunction context means an injury that cannot adequately be compensated for either by a later-issued permanent injunction, after a full adjudication on the merits, or by a later-issued damages remedy." Rio Grande Cmty. Health Ctr., Inc. v. Rullan, 397 F.3d 56, 76 (1st Cir. 2005). "[T]he measure of irreparable harm is not a rigid one; it has been referred to as a sliding scale, working in conjunction with a moving party's likelihood of success on the merits." Vaqueria Tres Monjitas, Inc. v. Irizarry, 587 F.3d 464, 485 (1st Cir. 2009). Further, "[d]istrict courts have broad discretion to evaluate the irreparability of

alleged harm and to make determinations regarding the propriety of injunctive relief." Id. "[T]he issuance of a preliminary injunction requires a showing of irreparable harm to the movant rather than to one or more third parties." CMM Cable Rep., Inc. v. Ocean Coast Props., Inc., 48 F.3d 618, 622 (1st Cir. 1995) (emphasis in original). Moreover, "plaintiffs seeking preliminary relief [are required] to demonstrate that irreparable injury is likely in the absence of an injunction. Winter v. Nat. Res. Def. Council, Inc., 555 U.S. 7, 22 (2008) (emphasis in original).

Plaintiffs correctly note, and Defendants do not contest, that injury to Planned Parenthood Federation's and Planned Parenthood Members' First Amendment rights constitutes irreparable harm to Plaintiffs sufficient to support the issuance of injunctive relief. "The loss of First Amendment freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury." Mahmoud v. Taylor, 606 U.S. __, 2025 WL 1773627, at *24 (U.S. June 27, 2025) (quoting Roman Cath. Diocese of Brooklyn v. Cuomo, 592 U.S. 14, 19 (2020) (per curiam)); see also Sindicato Puertorriqueño de Trabajadores v. Fortuño, 699 F.3d 1, 15 (1st Cir. 2012) (explaining "[t]here is no need for an extensive analysis of" irreparable harm where "plaintiffs have made a strong showing of likelihood of success on the merits of their First Amendment claim.").

It is no answer that Planned Parenthood Federation and its Members remain "free . . . to collaborate for the purpose of advocacy." Id. at 33. As explained above, membership is expressive association. Where Section 71113 encourages Members to give up their membership to avoid affiliation with a "prohibited entity," it causes a First Amendment injury. See NAACP v. Claiborne Hardware Co., 458 U.S. 886, 908 (1982) ("Effective advocacy of both public and private points of view, particularly controversial ones, is undeniably enhanced by group association.") (quoting NAACP v. Alabama ex rel. Patterson, 357 U.S. 449, 460 (1958)).

Where Section 71113 encourages Non-qualifying Planned Parenthood Members to disassociate from Planned Parenthood Federation, it also causes Planned Parenthood Federation to suffer First Amendment injury. A membership organization suffers injury from government action that has the effect of discouraging or reducing membership in that organization. Cf. NAACP, 357 U.S. at 459–60. Such action "is likely to affect adversely the ability of [the organization] and its members to pursue their collective effort to foster beliefs which they admittedly have the right to advocate, in that it may induce members to withdraw from the Association and dissuade others from joining it . . . ." Id. at 462–63. Section 71113 encourages Non-qualifying Members to give up their membership in Planned Parenthood Federation to avoid losing Medicaid funding on the basis of affiliation. Discouraging membership in Planned Parenthood Federation impairs its ability to engage in advocacy, particularly where Members not only pay dues, but participate in advocacy alongside Planned Parenthood Federation. Custer Decl. ¶¶ 10, 19 [Doc. No. 5-1]. In other words, a statute that discourages membership in Planned Parenthood Federation has the effect of weakening its message. Consequently, Section 71113 causes irreparable harm to Planned Parenthood Federation in addition to its Members.

In sum, where Section 71113 burdens Non-qualifying Members' affiliation with other Planned Parenthood Members, it diminishes Planned Parenthood Federation's and those Members' associational expression and causes First Amendment injury. And because Section 71113 encourages Non-qualifying Members to disassociate from Planned Parenthood Federation upon its implementation, Plaintiffs have shown they will suffer imminent, irreparable harm in the absence of a preliminary injunction.

C. *Balance of Hardships and the Public Interest*

The balance of hardships and public interest factors merge when the government is the opposing party. Nken v. Holder, 556 U.S. 418, 435 (2009) (factors merge in stay context); accord Massachusetts v. Nat'l Institutes of Health, 770 F. Supp. 3d 277, 295 (D. Mass. 2025) (factors merge in preliminary injunction context). Here, Plaintiffs argue that those factors favor preliminary injunctive relief because the public health consequences of Section 71113 will be dire. Pls.' Mem. 44 [Doc. No. 5]. Defendants contend that "Plaintiffs' proposed injunction threatens significant and irreparable harm to the Government and public" where it prevents implementation of "Congress['s] judgment about which entities it wishes to benefit from public funds." Defs.' Mem. 42 [Doc. No. 53].

There is a significant public interest in the implementation of duly enacted statutes. Dist. 4 Lodge of the Int'l Ass'n of Machinists & Aerospace Workers Loc. Lodge 207 v. Raimondo, 18 F.4th 38, 47 (1st Cir. 2021) ("[A]ny time a [government] is enjoined by a court from effectuating statutes enacted by representatives of its people, it suffers a form of irreparable injury.") (alterations in original). At the same time, when social policy burdens the exercise of First Amendment rights, the public interest in protecting those rights may outweigh the public interest in allowing such policy to take effect. See Roman Cath. Diocese of Brooklyn, 592 U.S. 14, 19–20 (2020) (concluding injunctive relief was warranted where coronavirus mitigation restrictions "str[uck] at the very heart of the First Amendment's guarantee of religious liberty."). And in general, there is no public interest in the perpetuation of unlawful government action. See Somerville Pub. Sch. v. McMahon, 139 F.4th 63, 76 (1st Cir. 2025). For this reason, there is a public interest in Congress's judgment "about which entities it wishes to benefit from public

funds," only so long as that judgment does not violate the equal protection clause and the First Amendment.

Where Plaintiffs have demonstrated a substantial likelihood of success on constitutional claims premised on impingement of First Amendment associational rights, injunctive relief is in the public interest. See Roman Cath. Diocese of Brooklyn, 592 U.S. at 19–20. Additionally, as Defendants point out, the disruption in patient care and corresponding adverse health outcomes caused by Section 71113 are properly considered in evaluating the effect of preliminary injunctive relief on the public interest, see Defs.' Mem. 39 [Doc. No. 53]; Rio Grande Cmty. Health Ctr., Inc. v. Rullan, 397 F.3d 56, 77 (1st Cir. 2005) (concluding district court appropriately found injunctive relief was in public interest where "any shut down of [FQHC health center] would adversely affect hundreds of Medicaid patients"), and those harms weigh in favor of injunctive relief. A preliminary injunction maintains Planned Parenthood Members' ability to seek Medicaid reimbursements—and maintain their status quo level of service to patients. And an injunction requiring Defendants to continue funding Medicaid reimbursements in accordance with the status quo imposes no additional Medicaid costs on Defendants, where there is no dispute that Medicaid funds will still be provided only for reimbursable healthcare services.

D. *Bond*

In accordance with the court's Amended Temporary Restraining Order [Doc. No. 46], Plaintiffs posted a nominal bond of $100. See Notice [Doc. No. 55]. Defendants argue that the court should further impose a bond in an amount "based on Planned Parenthood's estimates of the amount of Medicaid reimbursements its members receive each month." Defs.' Mem. 43 [Doc. No. 53].

Federal Rule of Civil Procedure 65(c) provides in relevant part: "The court may issue a preliminary injunction or a temporary restraining order only if the movant gives security in an amount that the court considers proper to pay the costs and damages sustained by any party found to have been wrongfully enjoined or restrained." The First Circuit has noted the "ample authority for the proposition that the provisions of Rule 65(c) are not mandatory and that a district court retains substantial discretion to dictate the terms of an injunction bond." Int'l Ass'n of Machinists & Aerospace Workers v. E. Airlines, Inc., 925 F.2d 6, 9 (1st Cir. 1991).

Here, in determining the amount of security, the court considers the costs and damages that Defendants would sustain if they were wrongfully enjoined. Defendants do not contend that Medicaid will have to reimburse more services because of the injunction but only that the reimbursement will be to disfavored providers rather than other providers. This would cause no monetary harm to the Medicaid program.

Additionally, the court finds that the constitutional harm to Members and the health consequences Medicaid patients who forego or cannot obtain care may suffer without a preliminary injunction outweigh any financial harm that Defendants might incur if they are wrongly enjoined.

Where Plaintiffs have already posted nominal bond under the court's Amended Temporary Restraining Order [Doc. No. 46], the court finds no additional bond necessary while a preliminary injunction is in place.

E. *Stay Pending Appeal*

Defendants request that any injunctive relief be stayed pending appeal. Defs.' Mem. 44 [Doc. No. 53]. A district court may stay injunctive relief while an appeal is pending. Fed. R. Civ.

P. 62(d). "A stay is not a matter of right, even if irreparable injury might otherwise result." Nken, 556 U.S. at 433 (2009) (citation omitted).

> In determining whether to stay an order pending appeal, courts consider
>
> (1) whether the stay applicant has made a strong showing that he is likely to succeed on the merits; (2) whether the applicant will be irreparably injured absent a stay; (3) whether issuance of the stay will substantially injure the other parties interested in the proceeding; and (4) where the public interest lies.

Id. at 426. "The party requesting a stay bears the burden of showing that the circumstances justify an exercise of that discretion." Id. at 433–34. "The first two factors . . . are the most critical. It is not enough that the [applicant's] chance of success on the merits be 'better than negligible.'" Id. at 434 (quoting Sofinet v. INS, 188 F.3d 703, 707 (7th Cir. 1999)).

Defendants have not shown that a stay should issue. Above, the court has concluded that Plaintiffs have shown a substantial likelihood of success on their equal protection claim based on their showing that Section 71113 draws a classification that burdens Plaintiffs' and Planned Parenthood Members' First Amendment rights. Accordingly, Defendants have not made a strong showing that they are likely to prevail on appeal.

The court has also concluded that enjoining enforcement of Section 71113 will risk at most minimal harm—financial or otherwise—to Defendants. Further, staying the preliminary injunction burdens Plaintiffs and Planned Parenthood Members with an immediate choice between exercising their associational rights and maintaining eligibility for Medicaid reimbursements. A stay should not issue where it would leave Plaintiffs unprotected from First Amendment injury. See Murthy v. Missouri, 601 U.S. __, 144 S. Ct. 7, 9 (2023) (Alito, J., dissenting) (disagreeing with stay of preliminary injunction where stay "allows the defendants to persist in committing . . . First Amendment violations . . . ."). And in light of the First

Amendment injury and harm to patient care that will occur absent an injunction, the public interest does not favor staying relief.

IV. Conclusion

For the foregoing reasons, Plaintiffs' Emergency Motion for a Preliminary Injunction [Doc. No. 4] is GRANTED in part and otherwise remains under advisement.

It is hereby ORDERED that:

1. Defendants, their agents, employees, appointees, successors, and anyone acting in concert or participation with Defendants are hereby enjoined from enforcing, retroactively enforcing, or otherwise applying the provisions of Section 71113 of "An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14," against Planned Parenthood Association of Utah and other Planned Parenthood Federation of America Members who will not provide abortion services as of October 1, 2025, or for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act for medical assistance furnished in fiscal year 2023 made directly to them did not exceed $800,000.

2. Defendants, their agents, employees, appointees, successors, and anyone acting in concert or participation with Defendants shall take all steps necessary to ensure that Medicaid funding continues to be disbursed in the customary manner and timeframes to Planned Parenthood Association of Utah and other Planned Parenthood Federation of America Members who will not provide abortion services as of October 1, 2025, or for which the total amount of Federal and State expenditures under the Medicaid program under Title XIX of the Social Security Act for medical assistance furnished in fiscal year 2023 made directly to them did not exceed $800,000.

3. Defendants shall provide a copy of this Order to all personnel within the Department of Health and Human Services and all state agencies involved with the disbursement of Medicaid funding.

4. Plaintiffs' nominal $100 bond posted with the court on July 15, 2025, will continue to be held by the court as the bond in this matter.

IT IS SO ORDERED.

July 21, 2025

/s/Indira Talwani
United States District Judge

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS, and PLANNED PARENTHOOD ASSOCIATION OF UTAH, Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as Secretary of the U.S. Department of Health and Human Services, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, MEHMET OZ, in his official capacity as Administrator of the Centers for Medicare & Medicaid Services, and CENTERS FOR MEDICARE & MEDICAID SERVICES, Defendants.	*	Civil Action No. 1:25-cv-11913-IT

MEMORANDUM & ORDER
July 28, 2025

TALWANI, D.J.

In this action, Plaintiffs Planned Parenthood Federation of America, Inc. ("Planned Parenthood Federation"), Planned Parenthood League of Massachusetts ("Planned Parenthood Massachusetts"), and Planned Parenthood Association of Utah ("Planned Parenthood Utah") allege that Section 71113 of An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14 ("the 2025 Reconciliation Act"), Pub. L. No. 119-21, 139 Stat. 72, 300–01 (July 4, 2025), violates the United States Constitution by subjecting Planned Parenthood Federation and its Members to a bill of attainder, by retaliating against them in violation of the First Amendment, and by denying them equal protection of the law. Plaintiffs assert further that the

provision, which directs that certain entities ("Prohibited Entities") may not receive federal Medicaid reimbursements for a one-year period, should not be read to apply to Planned Parenthood Members who do not independently satisfy Section 71113's requirements ("Non-Qualifying Members" [1]), and that if it is read to apply to these Members, it is unconstitutionally vague and violates Planned Parenthood Federation and these Members' First Amendment and Due Process rights.

Now before the court is Plaintiffs' Emergency Motion for a Preliminary Injunction [Doc. No. 4] seeking to preliminarily enjoin Defendants from enforcing Section 71113 against Planned Parenthood Members.[2] Defendants oppose the motion, asserting that "democratically elected components of the Federal Government collaborated to enact that provision consistent with their electoral mandates from the American people as to how they want their hard-earned taxpayer dollars spent." Defs.' Mem. 1 [Doc. No. 53]. In Defendants' view, "the law turns on action, not advocacy." Id. (emphasis in original).

Defendants' overview frames this inquiry: Is Section 71113 directed at entities solely because they provide elective abortions or also because of their advocacy? As explained below, Section 71113 burdens the exercise of Planned Parenthood Federation and its Members' First

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[1] The parties use this term in their briefing to describe Planned Parenthood Members that do not independently meet Section 71113's definition of "prohibited entity." See Pls.' Mem. 14 [Doc. No. 5]; Defs.' Mem. 6 [Doc. No. 53].

[2] The court's original Memorandum & Order [Doc. No. 62] addressed this motion in part and reserved in part. Id. at 3, 35. Defendants have filed a Notice of Appeal [Doc. No. 63] of that Order. "An appeal from the grant or denial of a preliminary injunction does not divest [this] court of jurisdiction or prevent it from taking other steps in the litigation while the appeal is pending." Contour Design, Inc. v. Chance Mold Steel Co., 649 F.3d 31, 34 (1st Cir. 2011) (quoting 11A Wright & Miller, Federal Practice and Procedure § 2962, at 438–39 (2d ed.1995)). Accordingly, this further Memorandum and Order now addresses the portions of the motion that the court took under advisement. To avoid repeated references to the first decision, the court has also included here the initial findings.

Amendment right of association and is thus subject to strict scrutiny review. Under that standard, Plaintiffs have demonstrated a substantial likelihood of success on Plaintiffs' First Amendment claim on behalf of those Members who do not provide elective abortions and on all Plaintiffs' equal protection claim based on the burdening of their right of association, where the law's classifications are not sufficiently tailored to stop elective abortions rather than advocacy.

The court also finds that Plaintiffs have demonstrated a substantial likelihood of success on Plaintiffs' Bill of Attainder claim.

In ordering relief, the court is not enjoining the federal government from regulating abortion and is not directing the federal government to fund elective abortions[3] or any healthcare service not otherwise eligible for Medicaid coverage. The court's order does not require the federal government to spend money not already appropriated for Medicaid or any other funds. Instead, this order grants preliminary relief that prevents Defendants from targeting a specific group of entities—Planned Parenthood Federation Members—for exclusion from reimbursements under the Medicaid program where Plaintiffs have established a substantial likelihood that they will succeed in establishing that such targeted exclusion violates the United

[3] The court adopts for purposes of this Memorandum and Order the term "elective abortions" that Defendants use to refer to abortions for which providers may not receive Medicaid reimbursement under the Hyde Amendment. See Defs.' Mem. 1 [Doc. No. 53]; see also Harris v. McRae, 448 U.S. 297, 302 (1980) ("Since September 1976, Congress has prohibited—either by an amendment to the annual appropriations bill . . . or by a joint resolution—the use of any federal funds to reimburse the cost of abortions under the Medicaid program except under certain specified circumstances.") (footnote omitted); see, e.g., Further Consolidated Appropriations Act, Pub. L. No. 118-47, §§ 506, 507(a), 138 Stat. 662, 703 (2024) (providing"[n]one of the funds appropriated in this Act . . . shall be expended for any abortion" except "(1) if the pregnancy is the result of an act of rape or incest" or "(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would . . . place the woman in danger of death unless an abortion is performed").

States Constitution, and where Plaintiffs satisfy the remaining requirements to obtain a preliminary injunction.

Accordingly, Plaintiffs' Emergency Motion for Preliminary Injunction [Doc. No. 4] is GRANTED, as set forth below.

I. Standard of Review

The issuance of a preliminary injunction before a trial on the merits can be held is an "extraordinary remedy" that shall enter only if a plaintiff makes a clear showing of entitlement to such relief. Winter v. Nat. Res. Def. Council, Inc., 555 U.S. 7, 22 (2008). The purpose of a preliminary injunction is "merely to preserve the relative positions of the parties until a trial on the merits can be held." Starbucks Corp. v. McKinney, 602 U.S. 339, 346 (2024) (quoting Univ. of Texas v. Camenisch, 451 U.S. 390, 395 (1981)). In evaluating a motion for a preliminary injunction, the court considers four factors:

> (1) the likelihood of success on the merits; (2) the potential for irreparable harm [to the movants] if the injunction is denied; (3) the balance of relevant impositions, i.e., the hardship to the nonmovant if enjoined as contrasted with the hardship to the movant if no injunction issues; and (4) the effect (if any) of the court's ruling on the public interest.

Esso Standard Oil Co. v. Monroig-Zayas, 445 F.3d 13, 17–18 (1st Cir. 2006) (quoting Bl(a)ck Tea Soc'y v. City of Boston, 378 F.3d 8, 11 (1st Cir. 2004)). The balancing of hardships and the analysis of the public interest merge when, as here, the government is the opposing party. Does 1–6 v. Mills, 16 F.4th 20, 37 (1st Cir. 2021) (citing Nken v. Holder, 556 U.S. 418, 435 (2009)).

The first factor is the most important: if the moving party cannot demonstrate a likelihood of success on the merits, "the remaining factors become matters of idle curiosity." New Comm Wireless Servs., Inc. v. SprintCom, Inc., 287 F.3d 1, 9 (1st Cir. 2002) (citing Weaver v. Henderson, 984 F.2d 11, 12 (1st Cir. 1993)). "To demonstrate likelihood of success on the merits, plaintiffs must show 'more than mere possibility' of success—rather, they must establish

a 'strong likelihood' that they will ultimately prevail." Sindicato Puertorriqueño de Trabajadores v. Fortuño, 699 F.3d 1, 10 (1st Cir. 2012) (quoting Respect Maine PAC v. McKee, 622 F.3d 13, 15 (1st Cir. 2010)).

II. Background

A. *Initial Findings*

The factual record before the court at the preliminary injunction stage as to the counts initially addressed by the court is as follows:

1. Medicaid

Medicaid is a joint state-federal funding program for medical assistance established by Title XIX of the Social Security Amendments of 1965. See Social Security Amendments of 1965, Pub. L. No. 89-97, § 121, 79 Stat. 286, 343–44 (1965); see also Costello Decl. ¶ 2 [Doc. No. 53-1] ("Medicaid is a joint state/federal partnership"). "Congress created Medicaid in 1965 to subsidize state efforts to provide healthcare to families and individuals 'whose income and resources are insufficient to meet the costs of necessary medical services.'" Medina v. Planned Parenthood South Atlantic, 606 U.S. __, 145 S. Ct. 2219, 2226 (2025) (quoting Armstrong v. Exceptional Child Center, Inc., 575 U.S. 320, 323 (2015) (quoting 42 U.S.C. § 1396-1)). States are not required to participate in Medicaid, but all states and the District of Columbia currently participate. Brindis Decl. ¶ 15 [Doc. No. 5-5].

Medicaid is the largest source of health coverage in the United States. Id. ¶ 14. Medicaid is administered at the State level, but the majority of Medicaid funding is provided by the federal government in every state. Custer Decl. ¶ 41 [Doc. No. 5-1]; Brindis Decl. ¶ 15 [Doc. No. 5-5]; see also Medina, 145 S. Ct. at 2226 ("Historically, the federal government has provided on average about 57% of the funds required to implement Medicaid, and States have supplied the balance.") (citing Congressional Research Service, Medicaid: An Overview 21 (2025)).

Under Title XIX, Congress has authorized annual appropriations for each fiscal year in "a sum sufficient" to carry out the purposes of the program, which "shall be used" for making payments to participating States. 42 U.S.C. § 1396-1. Medicaid is categorized as "mandatory spending" or "direct spending." Medicaid Financing and Expenditures, https://www.congress.gov/crs-product/R42640 (last accessed July 21, 2025). For the fiscal year ending September 30, 2025, Congress has appropriated $406,956,850,000 for grants to State Medicaid programs. Full-Year Continuing Appropriations and Extensions Act, 2025, Pub. L. No. 119-4 § 1101(a)(8), (c), 139 Stat. 9, 10–11 (Mar. 15, 2025) (appropriating amount provided in Further Consolidated Appropriations Act, Pub. L. No. 118-47, 138 Stat. 662 (2024)). Congress has appropriated an additional $261,063,820,000 for Medicaid for the first quarter of fiscal year 2026. Id. § 1109(b).

Each state that chooses to participate in Medicaid must submit a plan to the Secretary of Health and Human Services ("HHS") for approval. See 42 U.S.C. § 1396a(a), (b). The Secretary exercises authority to administer the Medicaid program through the Centers for Medicare and Medicaid Services ("CMS"). If a State's plan is approved, the State is entitled to Medicaid funds from the federal government for a percentage of the money it spends in providing covered medical care to eligible individuals. 42 U.S.C. § 1396b(a)(1); see also Arkansas Dep't of Health & Hum. Servs. v. Ahlborn, 547 U.S. 268, 275 (2006) (describing the Medicaid program). Federal law requires participating States to cover certain groups of individuals. See Medicaid, List of Medicaid Eligibility Groups, Mandatory Categorically Needy, https://www.medicaid.gov/medicaid/eligibility/downloads/list-of-eligibility-groups.pdf (last visited July 21, 2025). If a patient is entitled to receive benefits under the program's criteria, that

patient may enroll and receive health care services from Medicaid providers. Brindis Decl. ¶ 18 [Doc. No. 5-5].

Medicaid generally works through reimbursement; the program reimburses healthcare providers for covered services that they have delivered to patients. Costello Decl. ¶ 19 [Doc. No. 53-1]. CMS does not directly pay Medicaid providers. Id. ¶ 7. Instead, Medicaid provider payment occurs at the state level. Id. CMS issues advanced funding for State Medicaid programs through initial grant awards to States at the beginning of each quarter based on CMS-reviewed state expenditure estimates. Id. ¶ 3. Once CMS approves the advanced funding request, the State can draw down the federal advance for the allotted amount as costs are incurred. Id. ¶ 4 (citing 42 C.F.R. § 430.30(d)(3)). Every quarter, initial awards are reconciled to actual state expenditures following a finalization process that includes quarterly CMS reviews of state-submitted, actual expenditures and state draw-downs. Id. ¶ 5.

Congress has long prohibited the use of any federal funds to reimburse the cost of abortions under the Medicaid program except in limited circumstances. See Harris v. McRae, 448 U.S. 297, 302–03 (1980). At the same time, family planning services and supplies are a mandatory Medicaid benefit in accordance with Section 1905(a)(4)(C) of the Social Security Act. Costello Decl. ¶ 8 [Doc. No. 53-1].

2. Plaintiffs' Organization, Mission, and Services

a. Planned Parenthood Federation

Plaintiff Planned Parenthood Federation is a not-for-profit corporation organized under the laws of New York. Custer Decl. ¶ 7 [Doc. No. 5-1]. It is a national membership organization with 47 Members (the "Planned Parenthood Members"), including Planned Parenthood Massachusetts and Planned Parenthood Utah. Id. Planned Parenthood Federation is not itself a

healthcare provider and does not participate in Medicaid, but it supports its 47 Members, who do provide healthcare and receive Medicaid funding. Id. ¶¶ 7–8.

Planned Parenthood Federation administers accreditation standards for Planned Parenthood Members, promulgates shared medical standards and guidelines, and leads certain shared policy and program initiatives. Id. ¶ 13. Planned Parenthood Federation provides support, leadership, and guidance to Planned Parenthood Members. Id.

b. Planned Parenthood Members

Each Planned Parenthood Member is an independent non-profit organization that is incorporated and governed separately from other Members. Custer Decl. ¶ 9 [Doc. No. 5-1]; Lee Decl. ¶ 10 [Doc. No. 5-2] (Planned Parenthood Massachusetts); Ghorbani Decl. ¶¶ 1, 8–9 [Doc. No. 5-3] (Planned Parenthood Utah). Each Member has its own CEO, governance structure, staff, books, and operations. Custer Decl. ¶ 9 [Doc. No. 5-1]; Lee Decl. ¶ 10 [Doc. No. 5-2]; Ghorbani Decl. ¶ 9 [Doc. No. 5-3].

Planned Parenthood Members must agree to meet membership standards, which are outlined in Planned Parenthood Federation's bylaws and set by the Planned Parenthood Members. Custer Decl. ¶ 11 [Doc. No. 5-1]. Planned Parenthood Members elect Planned Parenthood Federation's board of directors, approve changes to Planned Parenthood Federation's bylaws and membership standards, approve Planned Parenthood Federation's long-range goals, and determine the amount each Planned Parenthood Member pays in annual dues to Planned Parenthood Federation. Id. ¶ 10.

Planned Parenthood Members provide medical services through nearly 600 health centers in 47 states and the District of Columbia and have a telehealth presence in all 50 states. Id. ¶¶ 7,

21. Each Planned Parenthood Member provides healthcare and education services in a distinct geographic area. Id. ¶ 9.

Collectively, Planned Parenthood Members provide sexual and reproductive healthcare to more people in the United States than any other provider. Id. ¶ 21. An estimated one out of every three women and one in ten men nationally has received care from a Planned Parenthood Member at least once in their lifetime, and this number is even higher among individuals with Medicaid, 43% of whom have received services from a Member health center. Id. In federal fiscal year 2023, Members served more than 2 million patients and provided approximately 9.4 million services. Id. ¶ 23.

Planned Parenthood Members offer various services depending on the needs of their communities. Id. ¶ 22. However, typical services include providing contraception (including long-acting reversible contraceptives), contraceptive counseling, physical exams, cancer screening, hormone therapy, testing and treatment for sexually transmitted infections ("STIs"), pregnancy testing and counseling, vasectomies, and colposcopies. Id. Members also provide abortion where it is legal. Id. Abortions comprise approximately 4% of Planned Parenthood Members' services nationwide. Id. ¶ 23.

Planned Parenthood Massachusetts provides services including contraception, cervical screenings, breast cancer exams, and STI tests. Lee Decl. ¶¶ 30–31 [Doc. No. 5-2]. Planned Parenthood Massachusetts provides abortion services to patients who choose to terminate a pregnancy, but no federal funds under the Medicaid program are used to reimburse Planned Parenthood Massachusetts for the cost of providing those services (except under the limited circumstances permitted by federal law). Id. ¶ 26. Planned Parenthood Utah provides for contraception, cervical screenings, breast cancer exams, testicular cancer screening, STI tests,

pregnancy testing, and abortions. Ghorbani Decl. ¶ 11 [Doc. No. 5-3]. No federal funds are used to reimburse abortion services (except under the limited circumstances permitted by federal law). Custer Decl. ¶ 45 [Doc. No. 5-1]. The remaining Planned Parenthood Members similarly receive no reimbursement for abortions from Medicaid funds or other federal funds except in permitted circumstances. Id. ¶ 45; Lee Decl. ¶ 26 [Doc. No. 5-2].

Planned Parenthood Members participate in Medicaid programs for services other than elective abortions in every state where they are able. Custer Decl. ¶ 43 [Doc. No. 5-1]. Planned Parenthood Massachusetts received $4,744,699.47 in Medicaid reimbursements during fiscal year 2023. Lee Decl. ¶ 29 [Doc. No. 5-2]. Medicaid reimbursements accounted for more than one third of Planned Parenthood Members' aggregate revenue in fiscal year 2023. Custer Decl. ¶ 44 [Doc. No. 5-1]. Some individual Members received over three quarters of their health services revenue from Medicaid reimbursement that year. Id. Approximately 51% of Planned Parenthood Members' patients rely on Medicaid for their healthcare, and half of visits to Planned Parenthood Member health centers are covered by Medicaid. Id. ¶ 43.

Planned Parenthood Massachusetts provided services to approximately 10,822 patients enrolled in Medicaid in 2024. Lee Decl. ¶¶ 30–31 [Doc. No. 5-2]. Planned Parenthood Utah provided service to approximately 2,096 patients enrolled in Medicaid in 2024. Ghorbani Decl. ¶ 24.

Some Planned Parenthood Members, including Planned Parenthood Utah and Planned Parenthood of Delaware, received less than $800,000 in Medicaid reimbursements during federal fiscal year 2023. Custer Decl. ¶¶ 63–64 [Doc. No. 5-1]; Ghorbani Decl. ¶ 20 [Doc. No. 5-3]; see also id. ¶ 24 (Planned Parenthood Utah received $706,251.02 in Medicaid reimbursements during fiscal year 2023).

Three Planned Parenthood Members—Gulf Coast, Planned Parenthood Greater Texas, and Planned Parenthood of Tennessee and North Mississippi—do not provide abortions because abortion is not legal in any state where their health centers are located. Custer Decl. ¶ 63 [Doc. No. 5-1].

c. Plaintiffs' Mission and Advocacy

Planned Parenthood Federation's mission is to ensure that people receive high-quality, inclusive, and comprehensive sexual and reproductive healthcare regardless of income, insurance, gender identity, sexual orientation, or race; to provide related educational services; to promote research on sexual and reproductive health; and to advocate for public policies that guarantee access to such services. Custer Decl. ¶¶ 7, 12 [Doc. No. 5-1]. Planned Parenthood Members share Planned Parenthood Federation's mission. Id. ¶ 12. Planned Parenthood Federation membership is important to Planned Parenthood Members' ability to fulfill their missions. Id. ¶ 15. Planned Parenthood Federation licenses the use of the Planned Parenthood name to each Planned Parenthood Member, and the Planned Parenthood name sends a message to the community that the Planned Parenthood Member stands for certain values and provides healthcare and educational services in furtherance of the shared Planned Parenthood mission. Id. ¶¶ 14–15. Working in furtherance of that mission, Planned Parenthood Members advocate for equitable access to the sexual and reproductive healthcare, including abortion, that Members and other non-profit sexual and reproductive healthcare providers offer. Id. ¶ 19.

Planned Parenthood Federation and Planned Parenthood Members advocate at the federal, state, and local levels to protect and expand access to reproductive healthcare services and information. Id. ¶ 75. Planned Parenthood Federation has advocated before Congress to codify the rights to abortion and contraception, block abortion bans, and repeal federal law that

prohibits federal funding of abortion. Id. Planned Parenthood Federation has also advocated for access to emergency contraception and medication abortion. Id. Planned Parenthood Members, and sometimes Planned Parenthood Federation, have litigated to secure abortion access and rights for their patients in federal and state courts. Id.

Planned Parenthood Action Fund, a related 501(c)(4) organization, advocates for policies that protect care for Planned Parenthood Members' patients and publishes a "congressional scorecard" to communicate with the public regarding their lawmakers' records and to activate constituents. Id. Additionally, Planned Parenthood Action Fund has supported campaigns for ballot initiatives. Id. Separately, Planned Parenthood Action Fund works with other national and local advocacy and political organizations to elect federal, state, and local officials who will support reproductive freedom. Id. Each Planned Parenthood Member may also have a related 501(c)(4) tax-exempt entity that works in furtherance of the Planned Parenthood mission through education, advocacy, and limited electoral activities. Id. ¶ 19.

3. Section 71113

Section 71113(a) of the 2025 Reconciliation Act provides that "no Federal funds that are considered direct spending[4] and provided to carry out a State plan under title XIX of the Social Security Act or a waiver of such a plan shall be used to make payments to a prohibited entity for items and services furnished during the 1-year period beginning on the date of the enactment of this Act . . . ." Pub. L. No. 119-21, § 71113(a), 139 Stat. 72, 300-01 (July 4, 2025). Section 71113(b)(1) defines the term "prohibited entity" as:

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[4] "Direct Spending" is defined with reference to 2 U.S.C. § 900(c)(8), which states that "[t]he term 'direct spending' means (A) budget authority provided by law other than appropriation Acts; (B) entitlement authority; and (C) the Supplemental Nutrition Assistance Program." Id. § 71113(b)(2)

> an entity, including its affiliates, subsidiaries, successors, and clinics--
>
> (A) that, as of the first day of the first quarter beginning after the date of enactment of this Act-
>
> > (i) is an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code;
> >
> > (ii) is an essential community provider described in section 156.235 of title 45, Code of Federal Regulations (as in effect on the date of enactment of this Act), that is primarily engaged in family planning services, reproductive health, and related medical care; and
> >
> > (iii) provides for abortions, other than an abortion-
> >
> > > (I) if the pregnancy is the result of an act of rape or incest; or
> > >
> > > (II) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed; and
>
> (B) for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act for medical assistance furnished in fiscal year 2023 made directly, or by a covered organization, to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded $800,000.

Id. § 71113(b)(1) (emphasis added).

Section 71113(c) also provides for $1,000,000 in appropriations to the Administrator of CMS for implementation. Id. § 71113(c).

4. Prohibited and Non-Qualifying Entities Under Section 71113

Planned Parenthood Members are non-profit entities and essential community providers who primarily engage in family planning services, reproductive health, and related medical care. See Lee Decl. ¶ 8 [Doc. No. 5-2]; Ghorbani Decl. ¶ 8 [Doc. No. 5-3]; Tosh Decl. ¶ 16 [Doc. No. 5-4]. Many Planned Parenthood Members, including Plaintiff Planned Parenthood Massachusetts, also provide abortion services and received more than $800,000 in Medicaid

reimbursements for non-abortion services in fiscal year 2023, and are thus "prohibited entities" under Section 71113. See Custer Decl. ¶ 47 [Doc. No. 5-1]; Lee Decl. ¶ 29 [Doc. No. 5-2]. The Center for Medicaid and CHIP Services ("CMCS") has "identified at least two non-Planned Parenthood entities" that have provided for elective abortions and otherwise meet the definition of "prohibited entity." Snyder Decl. ¶ 6 [Doc. No. 53-2].

Other types of providers, including community health centers ("CHCs") and federally qualified health centers ("FQHCs"), also use Medicaid programs to provide healthcare services to patients. Brindis Decl. ¶ 20 [Doc. No. 5-5]. However, unlike Planned Parenthood Members, CHCs and FQHCs usually do not specialize in family planning, instead providing services such as primary care, dental care, and/or mental health care. Id. Accordingly, even if they do perform elective abortions, Section 71113 does not prohibit them from receiving Medicaid reimbursements for other services.

Ten Planned Parenthood Members (the "Non-Qualifying Members") either do not offer abortion services or did not receive $800,000 in Medicaid reimbursement. Defendants contend that "CMS . . . has had no opportunity to analyze the legal and factual questions that it must consider to construe and apply the statute[,]" and has given no "concrete indication that the Government will conclude that the 'non-qualifying members' are covered by Section 71113[.]" Defs.' Mem. 24 [Doc. No. 53]. Defendants contend alternatively that "HHS and CMS could—depending on facts which have yet to be developed—permissibly construe the statute to cover 'non-qualifying members' if, on October 1, they are 'affiliates' of members that provide for abortions." Id. at 27.

5. Section 71113's Harm to Members and Patients

If Planned Parenthood Members are barred from receiving federal Medicaid reimbursement for their non-abortion services, Planned Parenthood Members across the country anticipate reducing the hours and programs they offer, terminating staff members, and eventually closing health centers. See Custer Decl. ¶¶ 4, 54–57 [Doc. No. 5-1]; Lee Decl. ¶¶ 40–42 [Doc. No. 5-2]; Ghorbani Decl. ¶¶ 6, 24 [Doc. No. 5-3]; Tosh Decl. ¶¶ 45–48 [Doc. No. 5-4]. Health centers that close may never reopen. Tosh Decl. ¶ 46 [Doc. No. 5-4].

A contraction in services causes a corresponding disruption to patient healthcare. See Custer Decl. ¶ 54 [Doc. No. 5-1]. Section 71113 creates an immediate disruption for over one million family planning patients who previously received care at Member health centers. Brindis Decl. ¶ 35 [Doc. No. 5-5]. The law "is already . . . forcing some Members to turn away patients enrolled in Medicaid; to attempt to refer them to other providers; or to offer Medicaid patients (who, by criteria of the program, have low incomes) the option to pay out-of-pocket for services where state law allows." Custer Decl. ¶ 49 [Doc. No. 5-1].

Planned Parenthood Massachusetts had nearly 150 scheduled appointments for Medicaid patients at their health centers on July 7 and July 8, and began informing those patients when Section 71113 was enacted that they could not use their Medicaid coverage for services at Planned Parenthood Massachusetts healthcare centers. Lee Decl. ¶ 4 [Doc. No. 5-2]. Many of those patients cannot afford to pay for care and cannot get timely care at another provider that accepts Medicaid. Id.

The law also disrupts healthcare for patients who do not rely on Medicaid. Custer Decl. ¶ 54 [Doc. No. 5-1]. Patients who can still access care at Member health centers could experience delays in receiving care. Id. ¶¶ 51, 54. Patients who seek healthcare elsewhere could

also face delays at those facilities, id. ¶ 56, and alternative providers may not be able to ramp up services quickly enough to fill the gap, Brindis Decl. ¶¶ 36–39 [Doc. No. 5-5]. Further, many Member health centers are located in medically underserved areas, primary care health professional shortage areas, and rural areas. Custer Decl. ¶ 55 [Doc. No. 5-1]. In many cases, patients who receive care at Planned Parenthood Member health centers will have no feasible alternative reproductive healthcare provider in their communities because of provider scarcity, language issues, unavailable services, or caps on Medicaid patients. Id. ¶¶ 24–29, 53–56; Lee Decl. ¶¶ 36–38 [Doc. No. 5-2]; Tosh Decl. ¶¶ 51–52, 54 [Doc. No. 5-4].

Patients are likely to suffer adverse health consequences where care is disrupted or unavailable. In particular, restricting Members' ability to provide healthcare services threatens an increase in unintended pregnancies and attendant complications because of reduced access to effective contraceptives, and an increase in undiagnosed and untreated STIs. Brindis Decl. ¶¶ 11, 58, 62–66 [Doc. No. 5-5]. Moreover, decreased access to contraceptives and the corresponding increase in the number of unintended pregnancies caused by excluding Planned Parenthood Members from Medicaid will likely result in an increased number of abortions. Id. ¶ 71. Restricting access to Member healthcare clinics will negatively affect more than just reproductive health; Members often serve as a source of primary care for patients. Id. ¶ 82. Planned Parenthood Federation reported in its most recent annual report that its Members provided 426,268 cancer screenings and other diagnostic procedures. Id. ¶ 84. Reduced access to screening services creates a likelihood that health issues will go undetected with attendant serious consequences. Id. ¶ 74.

B. *Further Findings—Legislative Backdrop*

As set forth above, Planned Parenthood Federation does not provide abortion services but does engage in and facilitate advocacy with and by its Members. Over the last several legislative sessions, members of Congress have introduced legislation seeking to defund "Planned Parenthood," culminating in the legislation at issue here. Throughout, the proposed and final legislation targeted Planned Parenthood Federation and its Members' receipt of federal funding as if Plaintiffs constituted a single entity. The proposed legislation did not target abortion services themselves.

Section 71113 is substantially similar to a provision proposed in a 2017 reconciliation bill. See H.R. 1628, 115th Cong. § 103 (2017). That bill similarly sought to bar "prohibited entit[ies]" from receiving Medicaid reimbursements for a one-year period. See id. § 103(a). The bill defined a "prohibited entity" based in part on that entity receiving more than $350 million in Medicaid reimbursements during fiscal year 2014. Id. § 103(b)(1)(B). Collectively, Planned Parenthood Members received over $350 million in Medicaid reimbursements that year, and the law would not have excluded any abortion providers other than Planned Parenthood Members from Medicaid funding. Custer Decl. ¶ 48 [Doc. No. 5-1].

When the House of Representatives considered the 2017 reconciliation bill, one former Representative explained that, in addition to tax cuts, spending cuts, and deficit reductions, it "represents . . . defunding Planned Parenthood," and asked rhetorically, "How long have we been fighting to defund Planned Parenthood?" 163 Cong. Rec. H2393, H2409 (Mar. 24, 2017) (Statement of Rep. Matt Gaetz (Fla.)). Another former Representative explained that "[t]his bill eliminates funding for Planned Parenthood," and that he was "excited to be part of it." Id. at H2414 (Statement of Rep. Roger Marshall (Kan.)). A third former Representative added, "I am

proud to defund Planned Parenthood once and for all." Id. at H2433 (Statement of Rep. Kevin Brady (Tex.)). The bill passed the House. See Roll Call 256 | Bill Number: H. R. 1628, Clerk of the U.S. House of Reps. (May 4, 2017), https://clerk.house.gov/Votes/2017256 (last accessed July 25, 2025). H.R. 1628 was then amended in the Senate to reduce the threshold for the funding criterion to $1,000,000. See S. Amend. 267 to H.R. 1628 § 106(b)(1)(B) (2017). Ultimately, this bill did not pass the Senate.

Attempts to exclude Planned Parenthood Federation and its Members from receiving federal funding continued in subsequent sessions. On January 9, 2023, Representative Lauren Boebert of Colorado introduced the Defund Planned Parenthood Act of 2023, H.R. 128, 118th Cong. (2023). This bill sought a one-year "moratorium on federal funding to Planned Parenthood Federation of America," barring Planned Parenthood Federation "or any affiliate or clinic of Planned Parenthood Federation" from receiving any federal funding "unless such entities certify that Planned Parenthood Federation of America affiliates and clinics will not perform, and will not provide any funds to any other entity that performs, an [elective] abortion[.]" Id. § 3(a). The bill provided further that "[a]ll funds that are no longer available to Planned Parenthood Federation of America, Inc. and its affiliates and clinics pursuant to this Act will continue to be made available to other eligible entities to provide women's health services." Id. § 2(3). The bill also provided for an additional $235,000,000 to be appropriated for the community health center program (under 42 U.S.C. § 254b) during the moratorium Id. § 4(a). As with all Federal funds, those funds could not be used for elective abortion. See id. § 4(b). At the same time, the bill did not bar funded community health center programs from providing abortion.

An identical bill was introduced a few days later by Representative Michelle Fischbach of Minnesota. See Defund Planned Parenthood Act of 2023, H.R. 371, 118th Cong. (2023).[5] Representative Fischbach reintroduced the bill in the current legislative session on January 9, 2025. See Defund Planned Parenthood Act of 2025, H.R. 271, 119th Cong. (2025).[6]

Separately, on November 2, 2023, Representative Robert B. Aderholt of Alabama introduced the Protect Funding for Women's Health Care Act, H.R. 6176, 118th Cong. (2023), a bill "[t]o prohibit Federal funding of Planned Parenthood Federation of America."[7] This bill

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[5] This bill was introduced with Representatives Christopher H. Smith (N.J.), Kat Cammack (Fla.), Andy Harris (Md.), Mike Johnson (La.), Glenn Grothman (Wis.), Andrew Clyde (Ga.), Earl L. Carter (Ga.), John W. Rose (Tenn.), Michael Waltz (Fla.), Michael Cloud (Tex.), Troy Balderson (Ohio), Diana Harshbarger (Tenn.), Robert B. Aderholt (Ala.), Tim Walberg (Mich.), Randy Feenstra (Iowa), Steve Womack (Ark.), Tracey Mann (Kan.), Jeff Duncan (S.C.), Jerry L. Carl (Ala.), Paul A. Gosar (Ariz.), Trent Kelly (Miss.), John R. Moolenaar (Mich.), Bob Good (Va.), Dan Newhouse (Wash.), Pete Sessions (Tex.), Mike Kelly (Pa.), Matthew M. Rosendale Sr. (Mont.), Blaine Luetkemeyer (Mo.), Barry Loudermilk (Ga.), Dan Bishop (N.C.), Darin LaHood (Ill.), Guy Reschenthaler (Pa.), Robert E. Latta (Ohio), Alexander X. Mooney (W. Va.), Rick W. Allen (Ga.), Andy Barr (Pa.), Gary J. Palmer (Ala.), Brian Babin (Tex.), Brad R. Wenstrup (Ohio), Glenn Thompson (Pa.), Michael Guest (Miss.), Bard Finstad (Minn.), Jake Ellzey (Tex.), Anna Paulina Luna (Fla.), Roger Williams (Tex.), Lloyd Smucker (Pa.), John Joyce (Pa.), James R. Baird (Ind.), Erin Houchin (Ind.), Burgess Owens (Utah), Ronny Jackson (Tex.), David Kustoff (Tenn.), and Beth Van Duyne (Tex.) as co-sponsors. See id. at 1.

[6] In this session, the bill was introduced with Representatives Houchin, Claudia Tenney (N.Y.), Feenstra, Dan Crenshaw (Tex.), Randy K. Weber Sr. (Tex.), Mike Ezell (Miss.), Moolenaar, Jackson, Harshbarger, Mary E. Miller (Ill.), Ellzey, Aderholt, Williams, Doug LaMalfa (Cal.), Nathaniel Moran (Tex.), Kelly (Pa.), Daniel Webster (Fla.), Van Duyne, Kustoff, Finstad, Kelly (Miss.), Mike Bost (Ill.), Richard Hudson (N.C.), Grothman, Richard McCormick (Ga.), Scott Fitzgerald (Wis.), Thompson, Womack, Mike Collins (Ga.), Smith, Mark E. Green (Tenn.), Mann, Stephanie I. Bice (Okla.), David Taylor (Ohio), Mark Alford (Mo.), Guest, Robert Onder (Mo.), Joyce, Babin, and Latta as cosponsors. See id. at 1.

[7] This bill was introduced with Representatives Gus M. Bilirakis (Fla.), McCormick, Cloud, Moolenaar, David Rouzer (N.C.), Waltz, Ashley Hinson (Iowa), Jim Banks (Ind.), Mooney, Miller, Russell Fry (S.C.), Guest, Williams, Keith Self (Tex.), Harris, Smucker, Mann, Ellzey, Lance Gooden (Tex.), Joyce, Reschenthaler, Jake LaTurner (Kan.), Rose, LaMalfa, Andrew Ogles (Tenn.), Gosar, Duncan, Charles J. "Chuck" Fleischmann (Tenn.), Houchin, Bruce Westerman (Ark.), Barry Moore (Ala.), Carl, Weber, Jackson, Aaron Bean (Fla.), and Palmer as cosponsors. See id. at 1.

provided for a "prohibition" rather than a moratorium on federal funding, stating that "no Federal funds may be made available to Planned Parenthood Federation of America, or to any of its affiliates, subsidiaries, successors, or clinics" without an end date or exception if clinics stopped providing abortions. Id. § 3(a). The bill made no references to abortion except that the bill "shall not be construed to . . . affect any limitation contained in an appropriations Act relating to abortion[.]" Id. § 3(b)(1). Representative Aderholt reintroduced this bill in the current legislative session on January 22, 2025. See Protect Funding for Women's Health Care Act, H.R. 599, 119th Cong. (2025).[8] Senator Joni Ernst of Iowa introduced an identical bill in the Senate on the same day. See Protect Funding for Women's Health Care Act, S. 177, 119th Cong. (2025).[9]

Finally, on January 23, 2025, Senator Rand Paul introduced the Defund Planned Parenthood Act, S. 203, 119th Cong. (2025),[10] a bill "[t]o prohibit Federal funding of Planned Parenthood Federation of America." The bill stated simply that "[n]otwithstanding any other provision of law, no Federal funds may be made available to Planned Parenthood Federation of America, or to any of its affiliates." Id. § 2. As with each of the other bills, the bill did not seek to bar other healthcare providers that provide abortion from receiving federal funds for other services. And as with the bills introduced by Representative Aderholt and Senator Ernst, this bill

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[8] This time, the bill was introduced with by Representatives Moolenaar, Crenshaw, Miller, Cloud, Ellzey, Webster, Rouzer, Dale W. Strong (Ala.), Rile Moore (W. Va.), Moore (Ala.), Tim Moore (N.C.), Green, and Hinson as co-sponsors. See id. at 1.

[9] This bill was introduced with Senators Chuck Grassley (Iowa), James Lankford (Okla.), Bill Cassidy (La.), Steve Daines (Mont.), Roger F. Wicker (Miss.), Deb Fischer (Neb.), Tim Sheehy (Mont.), John Thune (S.D.), James E. Risch (Idaho), Kevin Cramer (N.D.), Bill Hagerty (Tenn.), Thomas Tillis (N.C.), Jim Banks (Ind.), Josh Hawley (Mo.), and Marsha Blackburn (Tenn.) as cosponsors. See id. at 1.

[10] This Bill was introduced with Senators Roger Marshall (Kan.), Tommy Tuberville (Ala.), Markwayne Mullin (Okla.), Ted Budd (N.C.), Eric Schmitt (Mo.), Tillis, Ted Cruz (Tex.), and Banks as co-sponsors. See id. at 1.

contained no exception to the prohibition in the event that all Planned Parenthood Members stopped providing abortion services.

None of these bills were enacted. Instead, Congress turned to the 2025 Reconciliation bill. Representative Christopher Smith of New Jersey, a co-sponsor of the Defund Planned Parenthood Act of 2023 and the Defund Planned Parenthood Act of 2025, explained on the House floor on March 27, 2025: "reconciliation legislation offer[ed] an important opportunity to stop funding abortion purveyors like Planned Parenthood. This is an opportunity we cannot afford to miss." 171 Cong. Rec. E255 (2025) (statement of Rep. Smith). On April 29, 2025, Speaker Mike Johnson, a co-sponsor of the Defund Planned Parenthood Act of 2023, H.R. 371, 118th Cong. (2023), announced that "in the weeks ahead, the House is going to be working on the [Reconciliation Act] . . . and we're absolutely making it clear to everybody that this bill is going to redirect funds away from Big Abortion." SBA Pro-Life America, Speaker Mike Johnson at the SBA Pro-Life America Gala 2025, YouTube (May 1, 2025), https://youtu.be/vZFDkKzIfq4?si=TZrNGsZRJ9Oigsct&t=794 (last accessed July 25, 2025).

H.R. 1, a bill to provide for reconciliation, was reported out of the House of Representatives Committee on the Budget on May 20, 2025. See H.R. Rep. No. 119-106 (2025). Section 44126 of that bill contained the provision that, following amendments in the Senate, would become Section 71113. See H.R. Rep. 119-106, pt. 2, at 2203 (2025). Section 44126 defined a "prohibited entity" as one "including its affiliates, subsidiaries, successors, and clinics," that, *inter alia*, "provides for abortions" as of the enactment date and received more than $1,000,000 in Medicaid expenditures during a previous fiscal year. Id. at 2203–04. H.R. 1 barred prohibited entities from receiving Medicaid funds for ten years. Id. at 2203.

The majority Report of the House Committee on the Budget accompanying H.R. 1 included the following regarding Section 44126:

> Section 44126. Federal payments to prohibited entities[:] This section prohibits Medicaid funds to be paid to providers that are nonprofit organizations, that are essential community providers that are primarily engaged in family planning services or reproductive services, provide for abortions other than for Hyde Amendment exceptions, and which received $1,000,000 or more (to either the provider or the provider's affiliates) in payments from Medicaid payments in 2024.

H.R. Rep. No. 119-106, pt. 1, at 618 (2025). The minority Report identified Planned Parenthood as the subject of the legislation:

> Subtitle D also would prohibit federal Medicaid funding for Planned Parenthood and its affiliates across the country. Section 44126 creates a specific and narrow definition intended to target certain providers in the Medicaid program that separately, and without federal Medicaid funding, provide abortion services. . . . Even in the nearly two-dozen states that have outlawed or severely restricted abortion care, Medicaid beneficiaries would be unable to seek [other] care at Planned Parenthood as a result of this provision. Millions of Medicaid beneficiaries would be left without the ability to seek care from their provider of choice solely because of the Republicans' hostility towards Planned Parenthood and the ability for women to seek comprehensive reproductive health care.

Id. at 635.

On July 1, the bill was amended in the Senate in three respects: the historic Medicaid reimbursement threshold for a "prohibited entity" was lowered from $1,000,000 to $800,000, the period of exclusion from receiving Medicaid reimbursements was reduced from ten years to one year, and the deadline for ceasing abortion services was moved from the bill's effective date to October 1, 2025. See S. Amend. 2360 to H.R. 1 (July 1, 2025); Pub. L. No. 119-21, § 71113(b), 139 Stat. 72, 300-01 (July 4, 2025). The Senate passed H.R. 1, as amended, on July 1,[11] and the

[11] The amended bill was passed on a 51-50 vote, with Vice President JD Vance and all but two Republican Senators in favor, and Senators Susan Collins of Maine and Rand Paul of Kentucky and all other Senators opposed. See Roll Call Vote 119th Congress - 1st Session, U.S. Senate. Roll Call Votes,

House voted to concur in the Senate amendment on July 3, 2025.[12] The President signed the bill into law on Saturday, July 4, 2025, and this action was commenced on July 7, 2025. See Compl. [Doc. No. 1].

III. Likelihood of Success on the Merits

A. *Initial Findings: First Amendment Rights of Members That Do Not Provide Abortions*

Plaintiffs argue that if Section 71113 covers Planned Parenthood Members that do not provide abortions, the law imposes an unconstitutional condition on those Members and Planned Parenthood Federation's First Amendment right of association. Pls.' Mem. 35 [Doc. No. 5].[13] Defendants argue that Section 71113 merely "withholds funding based on whether entities provide abortion services," that Plaintiffs' arguments concerning "affiliates" are not ripe, and that "the word 'affiliate' here has nothing to do with expressive association." Defs.' Mem. 30, 33 [Doc. No. 53].

Planned Parenthood Federation and each Planned Parenthood Member are entitled to First Amendment protections. See Citizens United v. Fed. Election Comm'n, 558 U.S. 310, 355 (2010) (invalidating law on First Amendment grounds where "[t]he purpose and effect of [the]

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https://www.senate.gov/legislative/LIS/roll_call_votes/vote1191/vote_119_1_00372.htm. (last accessed, July 25, 2025).

[12] The motion to concur was passed on a 218-214 vote, with all but two Republican Representatives in favor, and Representative Brian Fitzpatrick of Pennsylvania and Thomas Massie of Kentucky and all other Representatives opposed. See Roll Call 190 | Bill Number: H. R. 1, Clerk of the U.S. House of Reps. (July 3, 2025), https://clerk.house.gov/Votes/2025190. (last accessed, July 25, 2025).

[13] Plaintiffs also claim that if Section 71113 covers Planned Parenthood Members who perform abortions but received less than $800,000 from Medicaid in fiscal year 2023, the law imposes an unconstitutional condition on these Members and Planned Parenthood Federation's right of association. Id. The court addresses this argument in connection with Plaintiffs' equal protection claim.

law is to prevent corporations, including . . . nonprofit corporations, from presenting both facts and opinions to the public"). "At the heart of the First Amendment lies the principle that each person should decide for himself or herself the ideas and beliefs deserving of expression, consideration, and adherence." Agency for Int'l Dev. v. All. for Open Soc'y Int'l, Inc., 570 U.S. 205, 213 (2013) (quoting Turner Broadcasting System, Inc. v. FCC, 512 U.S. 622, 641 (1994)). The Supreme Court has "long understood as implicit in the right to engage in activities protected by the First Amendment a corresponding right to associate with others" in pursuit of desired political, educational, or social ends. Roberts v. U.S. Jaycees, 468 U.S. 609, 622 (1984).

At the same time, the Constitution provides Congress exclusive power "[t]o lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States." U.S. const. art. I, § 8, cl. 1. This provision gives Congress broad discretion to spend for the "general [w]elfare." All. for Open Soc'y, 570 U.S. at 213. Congress may exercise this power by funding particular programs or activities, and it has "authority to impose limits on the use of such funds to ensure they are used in the manner Congress intends." Id. "The Government can, without violating the Constitution, selectively fund a program to encourage certain activities it believes to be in the public interest, without at the same time funding an alternative program which seeks to deal with the problem in another way." Rust v. Sullivan, 500 U.S. 173, 193 (1991). Generally, a party is limited to declining federal funds where it objects to a condition Congress places on receipt of those funds, even where that condition affects the recipient's First Amendment rights. All. for Open Soc'y, 570 U.S. at 214.

However, "the unconstitutional conditions doctrine forbids burdening the Constitution's enumerated rights by coercively withholding benefits from those who exercise them." Koontz v. St. Johns River Water Mgmt. Dist., 570 U.S. 595, 606 (2013). The government

> may not deny a benefit . . . on a basis that infringes [a recipient's] constitutionally protected interests—especially, [the recipient's] interest in freedom of speech. For if the government could deny a benefit to a [recipient] because of . . . constitutionally protected speech or associations, [the recipient's] exercise of those freedoms would in effect be penalized and inhibited. This would allow the government to "produce a result which (it) could not command directly."

Perry v. Sindermann, 408 U.S. 593, 597 (1972) (last alteration in original) (quoting Speiser v. Randall, 357 U.S. 513, 526 (1958)). The unconstitutional conditions doctrine bars the government from denying a benefit "on a basis that infringes [the recipient's] constitutionally protected . . . freedom of speech even if [the recipient] has no entitlement to that benefit." Rumsfeld v. F. for Acad. & Institutional Rts., Inc., 547 U.S. 47, 59 (2006) (quoting United States v. American Library Ass'n., Inc., 539 U.S. 194, 210 (2003)). Permissible conditions on funding "specify the activities Congress wants to subsidize[,]" while unconstitutional conditions "seek to leverage funding to regulate speech outside the contours of the [funded] program itself." All. for Open Soc'y, 570 U.S. at 214–15.

Contrary to Defendants' assertion, Section 71113 does not merely "withhold[] funding based on whether entities provide abortion services," but also based on whether "an entity, including its affiliates," provides abortion services.[14] Pub. L. No. 119-21, § 71113(b)(1), 139

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[14] Defendants' assertion that Plaintiffs' arguments concerning the law's application to "affiliates" are not ripe fails where, without injunctive relief, Planned Parenthood Members who do not provide abortion services will need to decide whether to disaffiliate from other Planned Parenthood Members before October 1, 2025, or risk ineligibility for Medicaid reimbursements because of their continuing membership in Planned Parenthood Federation. Therefore, even accepting Defendants' contention that there is uncertainty regarding how Defendants will apply Section 71113 to "affiliates," this uncertainty has an immediate chilling effect on Members' right of association. Given this chilling effect, and in light of Defendants' ultimate contention that "HHS and CMS could permissibly conclude (. . . depending on the facts as of October 1) that [Planned Parenthood Federation] members are all 'affiliates' within the meaning of the statute," id. at 29, Plaintiffs' unconstitutional conditions claim is ripe. See Franklin California Tax-Free Tr. v. Puerto Rico, 805 F.3d 322, 333 n.16 (1st Cir. 2015) (concluding case ripe where "plaintiffs

Stat. 72, 300 (July 4, 2025) (emphasis added). And Defendants assert that "two entities' existence under common control" would satisfy the dictionary definition of an "affiliate," and that, in Defendants' view, Planned Parenthood Federations' "membership standards," "accreditation standards," and "shared medical standards and guidelines," would be sufficient to show common control such that Planned Parenthood Members who do not provide abortion could be "affiliates" of the Planned Parenthood Members who do. See Defs.' Mem. 28 [Doc. No. 53].

To the extent that Section 71113 may be applied to Planned Parenthood Members who do not provide abortion, Plaintiffs are likely to succeed in establishing that the law impermissibly conditions the receipt of Medicaid reimbursements on these Members foregoing their right to associate with Planned Parenthood Federation and other Members. Members who do not provide abortions cannot escape the law's burden except by disassociating from Members that do. And because Section 71113 may be applied to Members who are affiliates of each other via the structure, governance, and membership requirements of Planned Parenthood Federation, disassociating with other Members requires disassociating from Planned Parenthood Federation itself.

While Defendants contend that Section 71113 does not regulate speech, the record demonstrates that Members' affiliation via their membership in Planned Parenthood Federation is expressive. Planned Parenthood Federation advocates before Congress, provides education and information about sexual and reproductive health, and through Planned Parenthood Action Fund, communicates with the public regarding lawmakers' voting records, supports campaigns for

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allege that the very enactment of the [statute], rather than the manner of enforcement" impaired plaintiffs' rights") (emphasis in original).

ballot initiatives, and supports candidates for federal, state, and local officials who will support reproductive freedom in furtherance of its mission. Custer Decl. ¶¶ 38, 75 [Doc. No. 5-1]. Members engage in those activities with Planned Parenthood Federation and each other. Id. ¶ 75. Additionally, Planned Parenthood Federation provides leadership and financial support to Members around shared policy and program initiatives. Id. ¶¶ 13, 75. Moreover, each Member licenses the use of the Planned Parenthood name, which expresses that each Member stands for particular values. Id. ¶¶ 14–15. Membership in Planned Parenthood Federation—and corresponding affiliation with other Members—is thus part and parcel with Planned Parenthood Members' associational expression.

The association between Members and with Planned Parenthood Federation is protected expression that is "outside the contours" of the Medicaid program. All. for Open Soc'y, 570 U.S. at 214–15. The "government is not required to subsidize activities that it does not wish to promote." Matal v. Tam, 582 U.S. 218, 240 (2017) (citing 570 U.S. at 215). Congress may set conditions "that define the limits" of a spending program by "specify[ing] the activities Congress wants to subsidize," but Congress may not set "conditions that seek to leverage funding to regulate speech outside the contours of the program itself." 570 U.S. at 214–15. Here, Medicaid funds healthcare services for qualifying low-income patients. Section 71113 places conditions on funds appropriated for Medicaid, including that a Medicaid provider may not affiliate with a "prohibited entity," which by definition provides abortions. But conditioning Medicaid funding on affiliation is not a limit on the services that Medicaid funds may reimburse.

Rust v. Sullivan provides an illustrative distinction. There, Congress barred project funds from funding particular conduct: abortion-related speech. 500 U.S. at 196. The regulations at issue allowed funded entities to engage in abortion-related speech so long as it was not funded

with project monies. Id. In upholding Congress's limitation on funding, the Supreme Court emphasized that "'unconstitutional conditions' cases involve situations in which the Government has placed a condition on the recipient of the subsidy rather than on the program or service," which "effectively prohibit[s] the recipient from engaging in the protected conduct outside the scope of the federally funded program." Id. at 197. That is what the government has done here. Congress has refused to fund particular recipients: affiliates of entities that provide abortion. Therefore, Members that do not provide abortion must disassociate from Planned Parenthood Federation to disaffiliate from Members that provide abortion to remain eligible for Medicaid funds. This requirement is unrelated to the scope of healthcare services that a Member provides.

The Supreme Court has underscored that the use of separate corporate entities, even where closely related, allows Congress to set conditions with its spending powers without unconstitutionally leveraging the funding to regulate speech. In Regan v. Taxation With Representation of Wash., 461 U.S. 540 (1983), the Court upheld a prohibition on "substantial lobbying activities" by 501(c)(3) organizations against an unconstitutional conditions challenge in part because the organization remained free to use a "dual structure . . . , with a § 501(c)(3) organization for non-lobbying activities and a § 501(c)(4) organization for lobbying," meaning the prohibition did not necessarily inhibit the organization's ability to engage in First Amendment activities. Id. at 544–45. In F.C.C. v. League of Women Voters of Cal., 468 U.S. 364 (1984), the Court struck down a statute barring any recipient of certain federal grants from engaging in editorializing. Id. at 400. In so holding, the Court explained that "if Congress were to adopt a revised version" of the statute "that permitted . . . broadcasting stations to establish 'affiliate' organizations" that engaged in editorializing, "such a statutory mechanism would plainly be valid" because "[a] public broadcasting station[] would be free . . . to make

known its views on matters of public importance through its nonfederally funded, editorializing affiliate without losing federal grants for its noneditorializing broadcast activities." Id.

Here, Section 71113 prohibits the type of dual structure that would have insulated the abortion restriction from an unconstitutional conditions challenge. Instead of merely prohibiting Planned Parenthood Members that receive Medicaid funds from providing abortions, the statute prohibits them from affiliating with entities that do. Moreover, the record is devoid of evidentiary support for Defendants' suggestion that Planned Parenthood entities share funds that are ultimately used for abortions. See Defs.' Mem. 35 [Doc. No. 53]. Therefore, restricting funds based on affiliation with an abortion provider operates only to restrict the associational right of Members that do not provide abortion.

Defendants also rely on Lyng v. Int'l Union, United Auto., Aerospace & Agr. Implement Workers of Am., UAW, 485 U.S. 360 (1988), where the Supreme Court found denying food stamps to households of striking workers did not violate the associational rights of household members or striking workers. Id. at 366. The Court there explained that a legislature's decision "not to subsidize the exercise of a fundamental right does not infringe the right." Id. at 368 (citing Regan, 461 U.S. at 549 (1983)). But the Court also acknowledged that associational rights "can be abridged even by government actions that do not directly restrict" the "ability to associate freely," and that the right to associate is "protected not only against heavy-handed frontal attack, but also from being stifled by more subtle governmental interference." Id. at 367 n.5 (citations omitted).

Further, in Lyng, the law denied eligibility for food stamps only while a household member was on strike. Id. at 362. And in upholding the law, the court explained:

> Exposing the members of an association to . . . economic reprisals . . . merely because of their membership in that group poses a much greater danger to the

> exercise of associational freedoms than does the withdrawal of a government benefit based not on membership in an organization but merely for the duration of one activity that may be undertaken by that organization.

Id. at 367 n.5. Here, Section 71113 withholds Medicaid reimbursements from Planned Parenthood Members who do not provide abortion so long as any other Member continues to do so. Where Section 71113 imposes a funding restriction based on the activity of other Members, the law burdens membership in Planned Parenthood Federation rather than a particular activity in which a Member engages. And the government may not burden a Member's associational right as a means of limiting other Members' undesired conduct. See NAACP v. Claiborne Hardware Co., 458 U.S. 886, 908 (1982) ("[T]he right to associate does not lose all constitutional protection merely because some members of the group may have participated in conduct . . . that itself is not protected.").

In sum, where Section 71113 disqualifies Planned Parenthood Members who do not provide abortion because of their affiliation with other Members who will continue to provide abortion, and where membership in Planned Parenthood Federation is expressive, Plaintiffs are likely to succeed in establishing that Section 71113 unconstitutionally conditions Medicaid reimbursements on these Members foregoing their First Amendment right of association.

B. *Further Findings: Bill of Attainder*

Plaintiffs argue that Section 71113 specifies Planned Parenthood Federation and its Members as the bill's object because "prohibited entity" is designed to ensure "nearly all of the entities covered are Planned Parenthood Members[,]" and the legislative history and context confirm that the law's purpose is to single out Planned Parenthood Federation and its Members for punishment. Pls.' Mem. 20 [Doc. No. 5]. Defendants argue that Section 71113 is not a bill of attainder because it applies to at least two entities that are not Planned Parenthood Members and

because it is based on future conduct. Defs.' Mem. 7, 11 [Doc. No. 53]. Defendants further contend that declining to provide federal funding is not legislative punishment. Id. at 7, 12.

Article I, Section 9 of the United States Constitution provides that "[n]o Bill of Attainder or ex post facto Law shall be passed." U.S. Const. art. I, § 9, cl. 3. "[T]he draftsmen of the Constitution sought to prohibit the ancient practice of the Parliament in England of punishing without trial 'specifically designated persons or ground.'" Selective Serv. Sys. v. Minnesota Pub. Int. Rsch. Grp., 468 U.S. 841, 847 (1984) (citation omitted). The Bill of Attainder Clause thus prohibits Congress from enacting a law that "legislatively determines guilt and inflicts punishment" on an identifiable party without a judicial trial. Nixon v. Adm'r of Gen. Servs., 433 U.S. 433 U.S. 425, 468 (1977). The Supreme Court has explained:

> [T]he Bill of Attainder Clause was intended not as a narrow, technical (and therefore soon to be outmoded) prohibition, but rather as an implementation of the separation of powers, a general safeguard against legislative exercise of the judicial function, or more simply—trial by legislature.

United States v. Brown, 381 U.S. 437, 442, (1965). Accordingly, the Clause is "not to be given a narrow historical reading," but instead must "be read in light of the evil the Framers had sought to bar: legislative punishment, of any form or severity, of specifically designated persons or groups." Id. at 447.

1. Specification

A bill of attainder must name the affected parties or apply "to easily ascertainable members of a group[.]" United States v. Lovett, 328 U.S. 303, 315 (1946). The scope of the class designated by a law does not determine whether it is a bill of attainder. See Nixon, 433 U.S. at 472 (explaining law that specified only individual to whom it applied "[did] not automatically offend the Bill of Attainder Clause"); Brown, 381 U.S. at 449–50 (holding statute prohibiting members of Communist Party from union employment constituted bill of attainder). A bill of

attainder satisfies the specification prong where it defines the affected class "entirely by irreversible acts committed by them" in the past. See Selective Serv. Sys., 468 U.S. at 848.

Where bills of attainder come in varying forms, four guideposts may be drawn from Supreme Court caselaw to direct the inquiry into whether legislation singles out a person or class within the meaning of the Bill of Attainder Clause. See SeaRiver Mar. Fin. Holdings, Inc. v. Mineta, 309 F.3d 662, 669 (9th Cir. 2002). First, courts "look to whether the statute or provision explicitly names the individual or class, or instead, describes the affected population in terms of general applicability." Id. (citing Selective Serv. Sys., 468 U.S. at 847; Nixon, 433 U.S. at 469–71). The second guidepost, which is "intricately connected with the first, is whether the identity of the individual or class was 'easily ascertainable' when the legislation was passed." Id. (quoting Brown, 381 U.S. at 448–49). Third, a court should "examine whether the legislation defines the individual or class by 'past conduct [that] operates only as a designation of particular persons.'" Id. (quoting Selective Serv. Sys., 468 U.S. at 847). Finally, a court should "review whether the past conduct defining the affected individual or group consists of 'irrevocable acts committed by them.'" Id. (quoting Selective Serv. Sys., 468 U.S. at 848).

The first guidepost does not support specification in this case because Section 71113 does not single out Planned Parenthood Federation or its Members by name. Instead, it defines the affected class using a generally-applicable set of conjunctive criteria.

However, Plaintiffs are likely to establish that Planned Parenthood Federation and its Members were the "easily ascertainable" target of the law when the legislation was passed. This is apparent from the statutory text. As set forth above, the law's conjunctive criteria create a narrow class of entities consisting almost entirely of Planned Parenthood Members. And where Defendants construe the term "affiliates" to apply based on membership in Planned Parenthood

Federation, Defs.' Mem. 28 [Doc. No. 53], Section 71113 targets Planned Parenthood Members who do not provide abortion—and continues to apply to those Members so long as any other Planned Parenthood Member provides abortion. At the same time, Defendants do not suggest that Section 71113 covers any entities that do not provide abortion except Planned Parenthood Members.

The inclusion of two additional entities in Section 71113's scope appears to be no more than collateral damage. The 2017 version of this provision included a $350 million Medicaid reimbursement threshold which, based on their aggregate revenues from Medicaid funding from 2014, captured only Planned Parenthood Members. See H.R. 1628, 115th Cong. § 103 (2017); Custer Decl. ¶ 48 [Doc. No. 5-1]. That threshold was then reduced to $1,000,000, but language aggregating Medicaid reimbursement to "affiliates" remained in place. S. Amend. 267 to H.R. 1628 (2017). Then, in 2025, the reconciliation bill first introduced in the House of Representatives included the same funding threshold. See H.R. 1. The Senate later reduced the $1,000,000 threshold to $800,000. See S. Amend. 2360 to H.R. 1, § 71115 (2025). But where reducing the funding threshold from $350 million to $800,000 resulted in coverage of only two entities not affiliated with Planned Parenthood Federation, the inclusion of those entities does not undercut Plaintiffs' showing that Section 71113's criteria were crafted to target Planned Parenthood Members.

Defendants focus on the third guidepost, contending that Section 71113 is not a bill of attainder because it "applies prospectively and attaches to an activity—providing for elective abortions—in which entities may choose not to engage." Defs.' Mem. 10 [Doc. No. 53]. But Section 71113 only attaches this restriction on providing elective abortions to the targeted entities. In other words, only entities that are nonprofit organizations, that are essential

community providers primarily engaged in family planning services or reproductive services, and which received $800,000 or more in fiscal year 2023—and such entities' affiliates—are prohibited from providing elective abortions under Section 71113. Pub. L. No. 119-21, § 71113(b), 139 Stat. 72, 300-01 (July 4, 2025). Rather than defining the affected entities based on whether they will provide abortion, the law establishes a class of entities and requires only those entities to stop providing abortion—and to disaffiliate with prohibited entities that do—to continue receiving Medicaid reimbursements.

The statute here is also distinguishable from the one at issue in Communist Party of U.S. v. Subversive Activities Control Bd., 367 U.S. 1 (1961), which Defendants cite for support. See Defs.' Mem. 10 [Doc. No. 53]. In Communist Party, the Court explained that "[s]o long as the incidence of legislation is such that the persons who engage in the regulated conduct, be they many or few, can escape regulation merely by altering the course of their own present activities, there can be no complaint of an attainder." 367 U.S. at 88. Under the law at issue, the plaintiff organization could avoid the law's burden—a registration requirement—if at any time it abandoned the activities triggering the requirement. Id. at 87. Therefore, "the application of the registration section [was] made to turn upon continuing contemporaneous fact; its obligations arise only because, and endure only so long as, an organization presently conducts operations of a described character." Id. (emphasis added). Here, as explained above, Section 71113 uses retrospective characteristics—*inter alia* the receipt of $800,000 in Medicaid reimbursements in 2023—to limit which entities are subject to the no-abortion requirement for receiving future Medicaid reimbursements. And then, if such an entity provides elective abortion as of October 1 (or affiliates with another prohibited entity that does), it is barred by Section 71113 from

receiving Medicaid reimbursements for any services rendered during the entire period that the law is effective. Therefore, the law does not "turn upon continuing contemporaneous fact." Id.

Ultimately, the third guidepost "seeks to determine whether the statute is retrospective, or whether it carries the potential to encompass a larger class than the individual or group allegedly targeted." SeaRiver Mar. Fin. Holdings, 309 F.3d at 670. Here, Congress has defined the outer bounds of the affected class with reference to past conduct. In other words, where Section 71113 limits its application to essential community providers that specialize in family planning and received $800,000 in Medicaid reimbursements in fiscal year 2023, the law will not encompass a larger class than Planned Parenthood Members and the two additional entities currently identified as falling within its scope.

In light of the above, the fourth guidepost bolsters Plaintiffs' contention that the law specifies Planned Parenthood Federation and its Members. "[T]he past conduct defining the affected . . . group[,]" most importantly, receiving $800,000 in Medicaid reimbursements in fiscal year 2023, "consists of 'irrevocable acts . . . .'" Id. at 669 (quoting Selective Serv. Sys., 468 U.S. at 848). Because no Planned Parenthood Member can change the amount of Medicaid reimbursements that they received in the past, no Member can "escape the effect of the legislation"—a prohibition on providing elective abortions—"by correcting the past conduct." Id. at 671. Conditioning the law's effect on surrendering separate activities does not allow a Member to "correct" its past participation in Medicaid, its registration as a non-profit, and its specialization in family planning and reproductive healthcare, which provide the basis for the statute's application. Cf. Selective Serv. Sys., 468 U.S. at 850–51 (concluding law withholding financial assistance from individuals who failed to register for the draft did not satisfy specification element where "a student who wants public assistance [could] correct" past failure

by registering late). Instead, as explained further below, Section 71113 imposes a condition that punishes the entities that Congress has singled out.

In sum, Plaintiffs have demonstrated that they are substantially likely to establish that Planned Parenthood Federation and its Members are the "easily ascertainable" target of Section 71113 where its criteria encompass every Planned Parenthood Member but only two entities not affiliated with Planned Parenthood Federation, and where Congress has set the outer bounds of the affected class based on retrospective criteria.

2. Punishment

"The deprivation of any rights, civil or political, previously enjoyed, may be punishment[.]" Cummings v. Missouri, 71 U.S. 277, 320 (1866). A burden imposed by law is not necessarily punishment. Selective Serv. Sys., 468 U.S. at 851. Nor is "the severity of a sanction . . . determinative of its character as punishment." Id. But "legislative intent to encourage compliance with the law does not establish that a statute is merely the legitimate regulation of conduct." Id. And "[p]unishment is not limited solely to retribution for past events, but may involve deprivations inflicted to deter future misconduct." Id. at 851–52. Accordingly, a bill of attainder may also impose punishment conditionally. Cummings, 71 U.S. at 324.

In deciding whether a statute imposes punishment, the Supreme Court has recognized three necessary inquiries: "(1) whether the challenged statute falls within the historical meaning of legislative punishment," i.e. the historical test, "(2) whether the statute, 'viewed in terms of the type and severity of burdens imposed, reasonably can be said to further nonpunitive legislative purposes,'" i.e. the functional test, and "(3) whether the legislative record 'evinces a congressional intent to punish,'" i.e. the motivational test. Selective Serv. Sys., 468 U.S. at 852; see also Foretich v. U.S., 351 F.3d 1198, 1218–26 (D.C. Cir. 2003). Whether a statute inflicts

punishment is ultimately circumstantial, and none of these inquiries are dispositive. See Selective Serv. Sys., 468 U.S. at 852–54.

Section 71113 most plainly deprives a "prohibited entity" of Medicaid funding. But the legislative punishment applied to these specified entities—entities who received $800,000 in Medicaid reimbursements in 2023, are registered as non-profits, provide care to underserved communities, and specialize in family planning and reproductive healthcare, or are affiliated with such entities—is that they alone may not receive Medicaid funding for other services if they perform elective abortion (or are affiliated with an entity that performs elective abortions). The law thus forces these entities—and not any other abortion providers—to choose between continuing to provide elective abortion and continuing to participate in Medicaid programs. And as explained above, where the law applies on the basis of affiliation, it encourages Members to disassociate from Planned Parenthood Federation, which impinges Planned Parenthood Federation's and its Members' associational rights. Therefore, the punishment inquiry must consider the financial, occupational, and constitutional harms that the law imposes.

Section 71113 is consistent with historical notions of punishment. Bills of attainder commonly included as punishment "imprisonment, banishment, and the punitive confiscation of property by the sovereign." Nixon, 433 U.S. at 474 & n.36–38 (collecting examples). Additionally, "barring designated . . . groups from participation in specified employments or vocations" is a historical form of punishment characteristic of bills of attainer. Id. at 474. Plaintiffs argue that section 71113 similarly "prevents Planned Parenthood Members from continuing to serve Medicaid patients." Pls.' Mem. 21 [Doc. No. 5]. The record supports Plaintiffs' contention that Section 71113 will force Planned Parenthood Members to turn away Medicaid patients, and lost revenue from Medicaid programs will force Member health centers to

reduce hours and may cause some health centers to close. Custer Decl. ¶¶ 4, 54–57 [Doc. No. 5-1]; Lee Decl. ¶¶ 40–42 [Doc. No. 5-2]; Ghorbani Decl. ¶¶ 6, 24 [Doc. No. 5-3]; Tosh Decl. ¶¶ 45–48 [Doc. No. 5-4].

Section 71113 on its face does not operate as a categorical exclusion from the Medicaid program, nor does it require any Member to cease operations. But a conditional exclusion can still constitute punishment within the scope of the bill of attainder clause. See Cummings, 71 U.S. at 325 (requiring loyalty oath to become clergy "adjudge[d] the punishment conditionally").

Where Section 71113 conditions a specified group's continued participation in Medicaid on Planned Parenthood Members surrendering certain activities, it fits within a historical category of bills of attainder. See Brown, 381 U.S. at 442 (explaining "some [bills of attainder] left the designated parties a way of escaping the penalty"); see also The Bounds of Legislative Specification: A Suggested Approach to the Bill of Attainder Clause, 72 Yale L.J. 330, 339–40 (1962) (collecting examples); Gaines v. Buford, 31 Ky. 481, 510 (1833) ("A British act of parliament might declare that if certain individuals or a class of individuals, failed to do a given act by a named day, they should be deemed to be, and treated, as convicted felons or traitors."). Moreover, where Section 71113 requires Planned Parenthood Members to stop providing elective abortions and to stop affiliating with entities that provide abortions to remain eligible for Medicaid reimbursements, and providing elective abortions where legal is part of their mission to "ensure access to sexual and reproductive health care services, including abortion" where it is legal, Custer Decl. ¶ 78 [Doc. No. 5-1], it prevents Planned Parenthood Members from engaging in a core part of their operation.

Turning to the functional inquiry, there is a poor fit between Section 71113 and any non-punitive legislative purpose. Section 71113 excludes few abortion providers from participating in

Medicaid programs and bars Planned Parenthood Members that do not provide abortion from receiving Medicaid funds. Moreover, the law does not reduce Medicaid funding for elective abortion where federal law already bars federal funding of elective abortion. Consequently, the law does little to further its purported non-punitive ends. See Defs.' Mem. 23 [Doc. No. 53]. And Defendants do not contend that Section 71113 reduces government spending, nor could they, where the law merely directs funding away from a small class of recipients and appropriates $1,000,000 to implement this change.

On the other hand, Section 71113 imposes severe burdens on both Planned Parenthood Federation and its Members. Planned Parenthood Members stand to lose over a third of their aggregate revenue because they are barred from receiving Medicaid reimbursements. Custer Decl. ¶ 44 [Doc. No. 5-1]. Further, to the extent a Member can remain eligible for Medicaid reimbursements by disaffiliating from Planned Parenthood Federation, Section 71113 imposes an unconstitutional condition that burdens Planned Parenthood Federation's and its Members' First Amendment rights. See supra Section III.A. And as explained above, where Section 71113 conditions Medicaid funding on Planned Parenthood Members ending their abortion services, it interferes with Members' ability to further their mission.

At bottom, Section 71113 requires each Member to disaffiliate with Planned Parenthood Federation and stop providing abortion to continue participating in Medicaid programs. But because collective advocacy and protecting access to legal abortion are core pieces of Planned Parenthood Federation and its Members' mission, imposing that choice kneecaps the entire organization. In light of the severe burdens on Planned Parenthood Federation and its Members on the one hand, and Section 71113's scant impact on abortion providers other than Planned Parenthood Members, Section 71113 cannot "reasonably . . . be said to further

nonpunitive legislative purposes." Nixon, 433 U.S. at 475; see also Foretich, 351 F.3d at 1222 (explaining "the [statute's] specificity . . . renders the asserted nonpunitive purposes suspect").

Finally, there is ample evidence that Congress intended to punish Planned Parenthood Federation and its Members. "Courts conduct [the] inquiry" into legislative intent "by reference to legislative history, the context or timing of the legislation, or specific aspects of the text or structure of the disputed legislation." Foretich, 351 F.3d at 1225 (citing Selective Serv. Sys., 468 U.S. at 855 n.15). Starting with the text and structure, Section 71113's conjunctive criteria substantiate Congress's intent to punish Planned Parenthood Federation and its Members where the criteria encompass every Planned Parenthood Member and exclude all but two other Medicaid providers.

Legislative context corroborates Plaintiffs' contention that Congress drafted these criteria with the intent to punish Planned Parenthood Federation and its Members. Section 71113 followed several explicit attempts to "defund Planned Parenthood" through bills first introduced in 2023, which were then reintroduced in 2025, each time with substantial support. See supra Section II.B. Those bills addressed funding for "Planned Parenthood" as a single entity by barring funding Planned Parenthood Federation or its "affiliates." See, e.g., Defund Planned Parenthood Act, S. 203, 119th Cong. (2025); see also supra, Section II.B. Section 71113 was similarly drafted to encompass "affiliates" of a "prohibited entity." And where Defendants do not contend that any entity is covered on the basis of affiliation with an entity providing abortion other than a Planned Parenthood Member, the language appears intended to implement previous attempts to defund Planned Parenthood Federation and its Members.

Statements by individual legislators also support the conclusion that Congress's intent was punitive. "[S]everal isolated statements" are not themselves "unmistakable evidence of

punitive intent." Selective Serv. Sys., 468 U.S. at 855 n.15 (citation omitted). But "[e]vidence in the legislative history can bolster [that] conclusion, however, where other factors suggest punitiveness." Foretich, 351 F.3d at 1225. And courts may look to statements by individual legislators in bill-of-attainder cases where "where the very nature of the constitutional question requires an inquiry into legislative purpose." United States v. O'Brien, 391 U.S. 367, 384 & n.30 (1968). Here, the legislative record includes a "call for the defunding of Planned Parenthood—Child Abuse, Incorporated" and a corresponding admonition that "[r]econciliation legislation offers an important opportunity to stop funding abortion purveyors like Planned Parenthood." See 171 Cong. Rec. E255 (daily ed. Mar. 27, 2025) (statement of Rep. Christopher H. Smith). While some legislators may view Planned Parenthood Federation and its Members guilty as charged, the purpose of the Bill of Attainder clause is designed to prevent "punishing without trial 'specifically designated persons or groups.'" Selective Serv. Sys., 468 U.S. at 847 (citation omitted).

In sum, Section 71113's text and structure make Planned Parenthood Federation and its Members the "easily ascertainable" target of the law. See Lovett, 328 U.S. at 315. And in light of the disconnect between the law and its purported ends on the one hand, and the severe burdens it imposes on Planned Parenthood Federation and its Members on the other, Plaintiffs are likely to establish that Congress singled them out with punitive intent. The legislative context bolsters that conclusion. Plaintiffs have thus demonstrated a substantial likelihood of success on their claim that Section 71113 is an unconstitutional bill of attainder.

C. *Initial and Further Findings: Equal Protection*

Plaintiffs assert that Section 71113 violates the Fifth Amendment's equal protection guarantee by barring Planned Parenthood Members from receiving Medicaid reimbursements

while "leaving virtually all other abortion providers outside its scope." Pls.' Reply 1 [Doc. No. 60]. Plaintiffs argue that Section 71113 is subject to strict scrutiny because it treats Planned Parenthood Members differently than other similarly-situated entities because of their association with Planned Parenthood Federation and each other. Pls.' Mem. 24–25 [Doc. No. 5]. And Plaintiffs argue that the law fails strict scrutiny because it applies based on a combination of conjunctive criteria that almost exclusively affect Planned Parenthood Members, Pls.' Reply 1 [Doc. No. 60], and are unrelated to the goal of reducing abortions. Pls.' Mem. 25 [Doc. No. 5].

Defendants argue that rational basis review applies and that the law effectuates a congressional desire "to reduce abortion and government subsidization of abortions." Defs.' Mem. 23 [Doc. No. 53]. Plaintiffs contend that "[e]ven if rational basis review applied, . . . [Section 71113] is unlawful." Pls.' Mem. 27 [Doc. No. 5].

1. Framework

"[T]he Due Process Clause of the Fifth Amendment forbids the Federal Government to deny equal protection of the laws." Vance v. Bradley, 440 U.S. 93, 94 n.1 (1979) (collecting cases). Equal protection claims under the Fifth Amendment are subject to the same analysis as 14th Amendment equal protection claims. Weinberger v. Wiesenfeld, 420 U.S. 636, 638 n.2 (1975).

Equal protection directs "that all persons similarly situated should be treated alike." City of Cleburne, Tex. v. Cleburne Living Ctr., 473 U.S. 432, 439 (1985); see also Walker v. Exeter Region Co-op. Sch. Dist., 284 F.3d 42, 44 n.2 (1st Cir. 2002) ("[T]he equal protection guaranteed by the Constitution forbids the legislature to select a person, natural or artificial, and impose upon him or it burdens and liabilities which are not cast upon others similarly situated.") (quoting Atchison, Topeka & Santa Fe R.R. Co. v. Matthews, 174 U.S. 96, 104 (1899)). Entities

are similarly situated where "a prudent person, looking objectively at the incidents, would think them roughly equivalent and the protagonists similarly situated." Barrington Cove Ltd. P'ship v. R.I. Hous. & Mortg. Fin. Corp., 246 F.3d 1, 8 (1st Cir. 2001) (citation omitted).

"The Constitution does not require things which are different in fact or opinion to be treated in law as though they were the same." Plyler v. Doe, 457 U.S. 202, 216 (1982) (quoting Tigner v. Texas, 310 U.S. 141, 147 (1940)). And a legislature "ha[s] substantial latitude to establish classifications that roughly approximate the nature of the problem perceived[.]" Id. Accordingly, legislative classifications are generally permissible so long as "the classification at issue bears some fair relationship to a legitimate public purpose." Id. "[A] statutory classification that neither proceeds along suspect lines nor infringes fundamental constitutional rights must be upheld against equal protection challenge if there is any reasonably conceivable state of facts that could provide a rational basis for the classification." F.C.C. v. Beach Commc'ns, Inc., 508 U.S. 307, 313 (1993). "[C]lassifications that . . . impinge upon the exercise of a 'fundamental right'" are "presumptively invidious." Plyler, 457 U.S. at 216–17. Accordingly, laws that impinge on fundamental rights, including "free speech rights, are subject to strict scrutiny and will only be upheld if 'precisely tailored to serve a compelling governmental interest.'" Rocket Learning, Inc. v. Rivera-Sanchez, 715 F.3d 1, 9 n.6 (1st Cir. 2013) (quoting Plyler, 457 U.S. at 217). In such cases, the government bears the burden to demonstrate "that its classification has been precisely tailored to serve a compelling governmental interest." Plyler, 457 U.S. at 216–17.

Under rational basis review, "a law will be sustained if it can be said to advance a legitimate government interest, even if the law seems unwise or works to the disadvantage of a particular group, or if the rationale for it seems tenuous." Romer v. Evans, 517 U.S. 620, 632 (1996). Although "legislation may impose special burdens upon defined classes in order to

achieve permissible ends[,]" equal protection "does require that, in defining a class subject to legislation, the distinctions that are drawn have 'some relevance to the purpose for which the classification is made.'" Rinaldi v. Yeager, 384 U.S. 305, 309 (1966). In other words, equal protection requires "some rationality in the nature of the class singled out." Id. at 308–09. And "[d]iscriminations of an unusual character especially suggest careful consideration to determine whether they are obnoxious to [equal protection]." Louisville Gas & Elec. Co. v. Coleman, 277 U.S. 32, 37–38 (1928).

2. Discussion

Section 71113 bars a narrow class of healthcare providers from receiving Medicaid funding. As relevant here, Section 71113 denies Medicaid reimbursements to non-profit health care providers that are "essential community provider[s] . . . primarily engaged in family planning services, reproductive health, and related medical care"[15] and provide abortion. See Pub. L. No. 119-21, § 71113(b)(1)(A), 139 Stat. 72, 300 (July 4, 2025). Additionally, a Planned Parenthood Member that provides abortion services but did not receive more than $800,000 in Medicaid funding in fiscal year 2023 may be precluded from receiving Medicaid funding as an "affiliate" of another Member that provides abortion services that meets the funding threshold.

These conjunctive criteria capture a small subset of abortion providers while leaving many others untouched. For-profit abortion providers may still receive Medicaid reimbursements

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[15] An "essential community provider" is

> a provider that serves predominantly low-income, medically underserved individuals . . . ; or a State-owned family planning service site, or governmental family planning service site, or not-for-profit family planning service site that does not receive Federal funding under special programs, including under Title X of the PHS Act, or an Indian health care provider . . . .

45 C.F.R. § 156.235(c).

for covered non-abortion services. Entities that provide abortions but are not "essential community providers" because they do not primarily serve predominantly low-income, medically underserved individuals may still engage in family planning services without losing Medicaid funding. Entities that provide abortions, are "essential community providers," but are not primarily engaged in family planning services, such as community health centers and federally qualified health centers, see Brindis Decl. ¶ 20 [Doc. No. 5-5], may also still receive Medicaid payments for their non-abortion services. And Section 71113 does not cover any abortion provider that did not receive more than $800,000 in Medicaid funding in fiscal year 2023 that is not an "affiliate" of an entity that meets the definition of "prohibited entity." On the record before the court, Section 71113 applies to 46 abortion providers: 37 Planned Parenthood Members that meet all of the "prohibited entity" criteria, 7 Planned Parenthood Members who provide abortion but received less than $800,000 in Medicaid reimbursements in fiscal year 2023 but may be considered "affiliated" with Planned Parenthood Members, see Custer Decl. ¶ 63 [Doc. No. 5-1], and two non-Planned Parenthood entities, see Snyder Decl. ¶ 6 [Doc. No. 53-2].

And where Section 71113 classifies on the basis of affiliation, it impinges on Planned Parenthood Federation's and each Member's right of association. Because Section 71113 applies to affiliates of an entity that provide abortion, no Member can escape the law's burden simply by ending its own abortion services. Instead, a Member must also disaffiliate from any Member that continues to provide abortion, which requires disassociating from Planned Parenthood Federation. As explained above, conditioning Medicaid reimbursements on disassociating from Planned Parenthood Federation burdens the right of association. Because Section 71113 impinges on a fundamental right, it is subject to strict scrutiny. See Rocket Learning, 715 F.3d at 9 n.6.

Defendants argue first that this classification is constitutionally permissible because Congress is "free to decline to provide taxpayer funds to entities that provide abortions." Defs.' Mem. 21 [Doc. No. 53]; see also id. at 14 ("Congress may make a policy choice not to contract with abortion providers even for covered medical care"). But Section 71113 is not "precisely tailored" toward denying taxpayer funds from abortion providers where Defendants do not dispute that the conjunctive criteria leave "virtually all abortion providers who participate in Medicaid—other than Planned Parenthood Members—unaffected" by the legislation. Pls.' Mem. 25 [Doc. No. 5] (emphasis in original).

Defendants argue further that Congress was free to focus on providers that are "primarily engaged in family planning services, reproductive health, and related medical care" because "they are likely to perform a higher proportion of abortions," and was free to distinguish between for-profit providers and non-profit providers because the non-profits already receive "an implicit government subsidy (in the form of tax-exempt status)[.]" Defs.' Mem. 22 [Doc. No. 53]. But Defendants do not explain how excluding providers of family planning services, reproductive healthcare, and related medical care that are not "essential community providers" because they do not serve predominantly low-income or medically underserved individuals relates to Congress's goal of reducing abortion. Nor do Defendants explain how denying Medicaid reimbursements from entities that already have "the benefit of a tax-exempt status" furthers that end.

Defendants also assert that Congress was free to address providers that specialize in family planning and received more than $800,000 in Medicaid funding in fiscal year 2023 because "[l]arger providers carry out more abortions and receive more government subsidies, so they are a natural first target." Id. at 22. But Defendants offer no basis for treating Planned

Parenthood Members who provide abortion but received less than $800,000 in Medicaid reimbursement, such as Planned Parenthood Utah, differently than other abortion providers who received less than $800,000 and are not Planned Parenthood Members. Congress sought to treat Planned Parenthood Federation and its Members as a single legal entity. See id. at 1 ("[T]he bill stops federal subsidies for Big Abortion."). But the record before the court establishes each Planned Parenthood Member is an independent organization. See Custer Decl. ¶ 9 [Doc. No. 5-1]. Consequently, restricting Medicaid reimbursements for them on the basis of affiliation creates the First Amendment problem described above.

At bottom, Defendants seek to justify each of Section 71113's criteria in isolation, but offer no justification for the classification established by the criteria in conjunction. Defendants argue that this classification is constitutionally permissible because Congress is "free to decline to provide taxpayer funds to entities that provide abortions." Defs.' Mem. 21 [Doc. No. 53]; see also id. at 14 ("Congress may make a policy choice not to contract with abortion providers even for covered medical care."). But Section 71113 does more: It declines Medicaid reimbursements on the basis of affiliation, and thus draws a classification that burdens a fundamental First Amendment right. Where Defendants have not shown the law is precisely tailored to serve a compelling governmental interest, Plaintiffs have demonstrated a substantial likelihood of success on their equal protection claim.

Moreover, Plaintiffs are likely to show that there is no rational relationship between the class burdened by Section 71113—comprised of 47 Planned Parenthood Members and two additional entities—and the goal of reducing abortion. As explained above, Section 71113 affects only a small number of abortion providers and leaves every other conceivable category unaffected. Defendants contend that Congress was free to focus on providers that are "primarily

engaged in family planning services, reproductive health, and related medical care" because "they are likely to perform a higher proportion of abortions." Defs.' Mem. 22 [Doc. No. 53]. But it is unclear how including only entities that are non-profits and provide medical services in underserved communities is in any way related to reducing abortion. Nor is it clear how withholding Medicaid reimbursements from Planned Parenthood Members who do not provide abortion furthers that end.

Defendants also suggest that Congress was free to focus on "Big Abortion." But the Member healthcare providers that are defunded by Section 71113 are separate legal entities. And as explained above, singling them out for exclusion from Medicaid on the basis of their affiliation with each other runs afoul of the First Amendment and the Bill of Attainder Clause.

Moreover, there is a substantial likelihood that Plaintiffs will establish that Section 71113 serves no legitimate fiscal purpose. The law includes a $1,000,000 appropriation for implementation, but it does not increase or decrease funding for Medicaid programs. See Pub. L. No. 119-21, § 71113(c), 139 Stat. 72, 300-01 (July 4, 2025). Instead, it directs Medicaid reimbursements away from 49 entities, nearly all of which are Planned Parenthood Members, and some of which do not provide abortions. Although Congress has significant latitude in allocating funds "from a finite pool of resources," Congress cannot pursue fiscal objectives "by discriminating against individuals or groups." See Lyng v. Int'l Union, United Auto., Aerospace & Agr. Implement Workers of Am., UAW, 485 U.S. 360, 373 (1988). Here, Section 71113 in effect makes only one change to Medicaid programs: It excludes Planned Parenthood Members (and two other entities) from participation. But discriminatory exclusion is not a permissible means to accomplish fiscal objectives, nor is it a permissible legislative end. See id.; cf. Romer,

517 U.S. at 632 (holding law failed rational basis review where scope of law "seem[ed] inexplicable by anything but animus toward the class it affects").

D. *First Amendment Retaliation*

Plaintiffs argue that Section 71113 amounts to retaliation against Planned Parenthood Federation and its Members "for [their] political stances on reproductive health." Pls.' Mem. 28 [Doc. No. 5].

Plaintiffs are likely to succeed in showing that Planned Parenthood Members engage in constitutionally protected expression and expressive association via membership in Planned Parenthood Federation. Planned Parenthood Federation advocates before Congress, provides education and information to Members' patients and the general public about sexual and reproductive health, and through Planned Parenthood Action Fund, communicates with the public regarding lawmakers' voting records, supports campaigns for ballot initiatives, supports candidates for federal, state, and local officials who will support reproductive freedom in furtherance of its mission. Custer Decl. ¶¶ 28, 75 [Doc. No. 5-1]. Members engage in those activities with Planned Parenthood Federation and each other. Id. ¶ 75. And each Member licenses the use of the Planned Parenthood name, which expresses that each Member shares Planned Parenthood Federation's mission. See id. ¶¶ 14–15.

At this stage, however, the court need not reach whether a law enacted by a congressional majority can constitute retaliation for engaging in activity protected by the First Amendment where Plaintiffs have demonstrated that they are likely to succeed in showing that Section 71113 constitutes a Bill of Attainder and denies Planned Parenthood Federation and its Members equal protection of the law.

IV. Irreparable Harm

"'Irreparable injury' in the preliminary injunction context means an injury that cannot adequately be compensated for either by a later-issued permanent injunction, after a full adjudication on the merits, or by a later-issued damages remedy." Rio Grande Cmty. Health Ctr., Inc. v. Rullan, 397 F.3d 56, 76 (1st Cir. 2005). "[T]he measure of irreparable harm is not a rigid one; it has been referred to as a sliding scale, working in conjunction with a moving party's likelihood of success on the merits." Vaqueria Tres Monjitas, Inc. v. Irizarry, 587 F.3d 464, 485 (1st Cir. 2009). Further, "[d]istrict courts have broad discretion to evaluate the irreparability of alleged harm and to make determinations regarding the propriety of injunctive relief." Id. "[T]he issuance of a preliminary injunction requires a showing of irreparable harm to the movant rather than to one or more third parties." CMM Cable Rep., Inc. v. Ocean Coast Props., Inc., 48 F.3d 618, 622 (1st Cir. 1995) (emphasis in original). Moreover, "plaintiffs seeking preliminary relief [are required] to demonstrate that irreparable injury is likely in the absence of an injunction. Winter v. Nat. Res. Def. Council, Inc., 555 U.S. 7, 22 (2008) (emphasis in original).

Plaintiffs correctly note, and Defendants do not contest, that injury to Planned Parenthood Federation's and Planned Parenthood Members' First Amendment rights constitutes irreparable harm to Plaintiffs sufficient to support the issuance of injunctive relief. "The loss of First Amendment freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury." Mahmoud v. Taylor, 606 U.S. __, 2025 WL 1773627, at *24 (U.S. June 27, 2025) (quoting Roman Cath. Diocese of Brooklyn v. Cuomo, 592 U.S. 14, 19 (2020) (per curiam)); see also Sindicato Puertorriqueño de Trabajadores v. Fortuño, 699 F.3d 1, 15 (1st Cir. 2012) (explaining "[t]here is no need for an extensive analysis of" irreparable harm where "plaintiffs have made a strong showing of likelihood of success on the merits of their First Amendment claim.").

It is no answer that Planned Parenthood Federation and its Members remain "free . . . to collaborate for the purpose of advocacy." Defs.' Mem. 33 [Doc. No. 53]. As explained above, membership in Planned Parenthood Federation constitutes expressive association. Where Section 71113 encourages Members to give up their membership to avoid affiliation with a "prohibited entity," it injures Members' First Amendment right to engage in collective advocacy. See NAACP v. Claiborne Hardware Co., 458 U.S. 886, 908 (1982) ("Effective advocacy of both public and private points of view, particularly controversial ones, is undeniably enhanced by group association.") (quoting NAACP v. Alabama ex rel. Patterson, 357 U.S. 449, 460 (1958)).

Where Section 71113 encourages Non-qualifying Planned Parenthood Members to disassociate from Planned Parenthood Federation, it also causes Planned Parenthood Federation to suffer First Amendment injury. A membership organization suffers injury from government action that has the effect of discouraging or reducing membership in that organization. Cf. NAACP, 357 U.S. at 459–60. Such action "is likely to affect adversely the ability of [the organization] and its members to pursue their collective effort to foster beliefs which they admittedly have the right to advocate, in that it may induce members to withdraw from the Association and dissuade others from joining it . . . ." Id. at 462–63. Section 71113 encourages Non-qualifying Members to give up their membership in Planned Parenthood Federation to avoid losing Medicaid funding on the basis of affiliation. Discouraging membership in Planned Parenthood Federation impairs its ability to engage in advocacy, particularly where Members not only pay dues, but participate in advocacy alongside Planned Parenthood Federation. Custer Decl. ¶¶ 10, 19 [Doc. No. 5-1]. In other words, a statute that discourages membership in Planned Parenthood Federation has the effect of weakening its message. Consequently, Section 71113 causes irreparable harm to Planned Parenthood Federation in addition to its Members. In sum,

where Section 71113 burdens Non-qualifying Members' affiliation with other Planned Parenthood Members, it diminishes Planned Parenthood Federation's and those Members' associational expression and causes First Amendment injury. Moreover, where Section 71113 forces only Planned Parenthood Members to decide whether stop performing elective abortions and and stop affiliating with entities that perform elective abortions to remain eligible for Medicaid reimbursements, the law injures constitutional rights protected by the Bill of Attainder clause, equal protection principles, and the First Amendment.

Additionally, Plaintiffs have shown that the disruption to patient care described above risks irreparable harm to Planned Parenthood Federation and its Members. Actions that make it more difficult for an organization to accomplish its primary mission constitute irreparable harm. See Victim Rts. L. Ctr. v. United States Dep't of Educ., __ F. Supp. 3d __, 2025 WL 1704311, at *18 (D. Mass. June 18, 2025). Where Section 71113 has and will continue to force Member health centers to cancel appointments for Medicaid patients and reduce hours and staffing, it interferes with Planned Parenthood Federation and its Members' mission to ensure that "people can receive high-quality, inclusive, and comprehensive sexual and reproductive healthcare" "regardless of income[.]" Custer Decl. ¶ 12 [Doc. No. 5-1]. Relatedly, Planned Parenthood Members' inability to provide timely or comprehensive patient care is likely to damage the public perception that Planned Parenthood Members "stand[] for certain values and provide[] high-quality health care . . . ." Id. ¶ 15. And "[b]ecause injuries to goodwill and reputation are not easily quantifiable, courts often find this type of harm irreparable." Ross-Simons of Warwick, Inc. v. Baccarat, Inc., 217 F.3d 8, 13 (1st Cir. 2000).

In sum, injunctive relief is necessary to prevent Planned Parenthood Federation and its Members from suffering irreparable injury.

V. Balance of Hardships and the Public Interest

The balance of hardships and public interest factors merge when the government is the opposing party. Nken v. Holder, 556 U.S. 418, 435 (2009) (factors merge in stay context); accord Massachusetts v. Nat'l Institutes of Health, 770 F. Supp. 3d 277, 295 (D. Mass. 2025) (factors merge in preliminary injunction context). Plaintiffs argue that those factors favor preliminary injunctive relief because the public health consequences of Section 71113 will be dire. Pls.' Mem. 44 [Doc. No. 5]. Defendants contend that "Plaintiffs' proposed injunction threatens significant and irreparable harm to the Government and public" where it prevents implementation of "Congress['s] judgment about which entities it wishes to benefit from public funds." Defs.' Mem. 42 [Doc. No. 53].

There is a significant public interest in the implementation of duly enacted statutes. Dist. 4 Lodge of the Int'l Ass'n of Machinists & Aerospace Workers Loc. Lodge 207 v. Raimondo, 18 F.4th 38, 47 (1st Cir. 2021) ("[A]ny time a [government] is enjoined by a court from effectuating statutes enacted by representatives of its people, it suffers a form of irreparable injury.") (alterations in original). Here, however, any injury is minimal. Section 71113 was enacted as part of budget reconciliation legislation. See generally Pub. L. No. 119-21, 139 Stat. 72 (July 4, 2025). But Section 71113 itself has a negligible impact on the federal budget. It does not limit Medicaid funding and it includes an appropriation of $1,000,000 to support implementation. Id. § 71113(c). Nor does not increase or decrease funding for Medicaid programs. And the court's order here does not require the government to expend funds for services other than those the government has approved. Further, the court's order does not bear on legitimate policy choices that are within the province of Congress, including whether Medicaid funding may be used for abortion or even whether abortion should be discouraged. Instead, the court's order only enjoins

the statute's targeted exclusion of a disfavored group of entities from receiving Medicaid funding that has already been appropriated.

Moreover, when social policy burdens the exercise of First Amendment rights, the public interest in protecting those rights may outweigh the public interest in allowing such policy to take effect. See Roman Cath. Diocese of Brooklyn, 592 U.S. 14, 19–20 (2020) (concluding injunctive relief was warranted where coronavirus mitigation restrictions "str[uck] at the very heart of the First Amendment's guarantee of religious liberty."). And in general, there is no public interest in the perpetuation of unlawful government action. See Somerville Pub. Sch. v. McMahon, 139 F.4th 63, 76 (1st Cir. 2025). For this reason, there is a public interest in Congress's judgment "about which entities it wishes to benefit from public funds," only so long as that judgment does not violate the constitution.

Where Plaintiffs have demonstrated a substantial likelihood of success on constitutional claims premised on impingement of First Amendment associational rights, singling out Planned Parenthood Federation and its Members for legislative punishment, and denial of equal protection, injunctive relief is in the public interest. See Roman Cath. Diocese of Brooklyn, 592 U.S. at 19–20.

Additionally, as Defendants point out, the disruption in patient care and corresponding adverse health outcomes caused by Section 71113 are properly considered in evaluating the effect of preliminary injunctive relief on the public interest, see Defs.' Mem. 39 [Doc. No. 53]; Rio Grande Cmty. Health Ctr., Inc. v. Rullan, 397 F.3d 56, 77 (1st Cir. 2005) (concluding district court appropriately found injunctive relief was in public interest where "any shut down of [FQHC health center] would adversely affect hundreds of Medicaid patients"), and those harms weigh in favor of injunctive relief. Plaintiffs' have demonstrated that before this case may be

litigated through judgment, services will be cut and many Member health centers will be forced to close if no injunction enters. See Custer Decl. ¶¶ 4, 54-57, 78 [Doc. No. 5-1]; Lee Decl. ¶¶ 40-42 [Doc. No. 5-2]; Ghorbani Decl. ¶¶ 6, 24 [Doc. No. 5-3]; Tosh Decl. ¶¶ 45-48 [Doc. No. 5-4]. Some of those health centers may never be able to reopen. See Tosh Decl. ¶ 46 [Doc. No. 5-4]. This is particularly antithetical to the public interest, where, by Section 71113(b)(1)(A)(ii)'s own definition, the entities impacted by the legislation "serve[] predominantly low-income, medically underserved individuals." See 45 C.F.R. § 156.235(c).

A preliminary injunction maintains Planned Parenthood Members' ability to seek Medicaid reimbursements—and maintain their status quo level of service to patients. And an injunction requiring Defendants to continue funding Medicaid reimbursements in accordance with the status quo imposes no additional Medicaid costs on Defendants, where there is no dispute that Medicaid funds will still be provided only for reimbursable healthcare services.

VI. Bond

In accordance with the court's Amended Temporary Restraining Order [Doc. No. 46], Plaintiffs posted a nominal bond of $100. See Notice [Doc. No. 55]. Defendants argue that the court should further impose a bond in an amount "based on Planned Parenthood's estimates of the amount of Medicaid reimbursements its members receive each month." Defs.' Mem. 43 [Doc. No. 53].

Federal Rule of Civil Procedure 65(c) provides in relevant part: "The court may issue a preliminary injunction or a temporary restraining order only if the movant gives security in an amount that the court considers proper to pay the costs and damages sustained by any party found to have been wrongfully enjoined or restrained." The First Circuit has noted the "ample authority for the proposition that the provisions of Rule 65(c) are not mandatory and that a

district court retains substantial discretion to dictate the terms of an injunction bond." Int'l Ass'n of Machinists & Aerospace Workers v. E. Airlines, Inc., 925 F.2d 6, 9 (1st Cir. 1991).

Here, in determining the amount of security, the court considers the costs and damages that Defendants would sustain if they were wrongfully enjoined. Defendants do not contend that Medicaid will have to reimburse more services because of the injunction but only that the reimbursement will be to disfavored providers rather than other providers. Accordingly, any harm that Defendants would sustain is not a monetary harm.

Additionally, the court finds that the constitutional harm to Members and the health consequences Medicaid patients who forego or cannot obtain care may suffer without a preliminary injunction outweigh any financial harm that Defendants might incur if they are wrongly enjoined.

Where Plaintiffs have already posted nominal bond under the court's Amended Temporary Restraining Order [Doc. No. 46], the court finds no additional bond necessary while a preliminary injunction is in place.

VII. Stay Pending Appeal

Defendants request that any injunctive relief be stayed pending appeal. Defs.' Mem. 44 [Doc. No. 53]. A district court may stay injunctive relief while an appeal is pending. Fed. R. Civ. P. 62(d). "A stay is not a matter of right, even if irreparable injury might otherwise result." Nken, 556 U.S. at 433 (2009) (citation omitted).

In determining whether to stay an order pending appeal, courts consider

> (1) whether the stay applicant has made a strong showing that he is likely to succeed on the merits; (2) whether the applicant will be irreparably injured absent a stay; (3) whether issuance of the stay will substantially injure the other parties interested in the proceeding; and (4) where the public interest lies.

Id. at 426. "The party requesting a stay bears the burden of showing that the circumstances justify an exercise of that discretion." Id. at 433–34. "The first two factors . . . are the most critical. It is not enough that the [applicant's] chance of success on the merits be 'better than negligible.'" Id. at 434 (quoting Sofinet v. INS, 188 F.3d 703, 707 (7th Cir. 1999)).

Defendants have not shown that a stay should issue. Above, the court has concluded that Plaintiffs have shown a substantial likelihood of success on their First Amendment, Bill of Attainder and Equal Protection claims. Accordingly, Defendants have not made a strong showing that they are likely to prevail on appeal.

The court has also concluded that enjoining enforcement of Section 71113 will risk minimal harm to Defendants. Further, staying the preliminary injunction burdens Plaintiffs and Planned Parenthood Members with an immediate choice between exercising their associational rights and maintaining eligibility for Medicaid reimbursements. A stay should not issue where it would leave Plaintiffs unprotected from First Amendment injury. See Murthy v. Missouri, 601 U.S. __, 144 S. Ct. 7, 9 (2023) (Alito, J., dissenting) (disagreeing with stay of preliminary injunction where stay "allows the defendants to persist in committing . . . First Amendment violations . . . ."). And in light of the First Amendment injury, the likely unconstitutional bill of attainder and violation of the equal protection clause, and harm to patient care that will occur absent an injunction, the public interest does not favor staying relief.

VIII. Conclusion

For the foregoing reasons, Plaintiffs' Emergency Motion for a Preliminary Injunction [Doc. No. 4] is GRANTED.

It is hereby ORDERED that:

1. Defendants, their agents, employees, appointees, successors, and anyone acting in concert or participation with Defendants are hereby enjoined from enforcing, retroactively

enforcing, or otherwise applying the provisions of Section 71113 of "An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14," against Planned Parenthood Association of Utah, Planned Parenthood League of Massachusetts, and all other members of Planned Parenthood Federation of America, Inc.;

2. Defendants, their agents, employees, appointees, successors, and anyone acting in concert or participation with Defendants shall take all steps necessary to ensure that Medicaid funding continues to be disbursed in the customary manner and timeframes to Planned Parenthood Association of Utah, Planned Parenthood League of Massachusetts, and all other Members of Planned Parenthood Federation of America, Inc.;

3. Defendants shall provide a copy of this Order to all personnel within the Department of Health and Human Services and all state agencies involved with the disbursement of Medicaid funding; and

4. Plaintiffs' nominal $100 bond posted with the court on July 15, 2025, will continue to be held by the court as the bond in this matter.

IT IS SO ORDERED.

July 28, 2025

/s/Indira Talwani
United States District Judge

Nos. 25-1698, 25-1755

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.; PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS; PLANNED PARENTHOOD ASSOCIATION OF UTAH,

Plaintiffs-Appellees,

v.

ROBERT F. KENNEDY, JR., in the official capacity as Secretary of the U.S. Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; MEHMET OZ, in the official capacity as Administrator of the Centers for Medicare & Medicaid Services; CENTERS FOR MEDICARE & MEDICAID SERVICES,

Defendants-Appellants.

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

APPENDIX

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CERTIFICATE OF SERVICE

APPEAL,STAYED

United States District Court
District of Massachusetts (Boston)
CIVIL DOCKET FOR CASE #: 1:25–cv–11913–IT

Planned Parenthood Federation of America, Inc. et al v. Kennedy et al
Assigned to: Judge Indira Talwani
related Case: 1:25–cv–12118–IT
Case in other court: USCA – First Circuit, 25–01698
USCA – First Circuit, 25–01755
Cause: 28:2201 Injunction

Date Filed: 07/07/2025
Jury Demand: None
Nature of Suit: 890 Other Statutory Actions
Jurisdiction: U.S. Government Defendant

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V.

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Date Filed	#	Docket Text
07/07/2025	1	COMPLAINT *for Declaratory and Injunctive Relief* against All Defendants Filing fee: $ 405, receipt number AMADC–11104085 (Fee Status: Filing Fee paid), filed by Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts. (Attachments: # 1 Civil Cover Sheet, # 2 Category Form)(Hogue, Sharon) (Entered: 07/07/2025)
07/07/2025	2	CORPORATE DISCLOSURE STATEMENT by Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts. (Hogue, Sharon) (Entered: 07/07/2025)
07/07/2025	3	MOTION for Leave to File Excess Pages by Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts.(Hogue, Sharon) (Entered: 07/07/2025)
07/07/2025	4	Emergency MOTION for Temporary Restraining Order *and Preliminary Injunction* by Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts. (Attachments: # 1 Text of Proposed Order)(Hogue, Sharon) (Entered: 07/07/2025)
07/07/2025	5	MEMORANDUM in Support re 4 Emergency MOTION for Temporary Restraining Order *and Preliminary Injunction* filed by Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts. (Attachments: # 1 Exhibit 1 – Declaration of Kimberly Custer, # 2 Exhibit 2 – Declaration of Dominique Lee, # 3 Exhibit 3 – Declaration of Shireen Ghorbani, # 4 Exhibit 4 – Declaration of Jenna Tosh, # 5 Exhibit 5 – Declaration of Claire D. Brindis)(Hogue, Sharon) (Entered: 07/07/2025)
07/07/2025	6	NOTICE of Appearance by Sharon Hogue on behalf of Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts (Hogue, Sharon) (Entered: 07/07/2025)

07/07/2025	7	MOTION for Leave to Appear Pro Hac Vice for admission of Alan Schoenfeld Filing fee: $ 125, receipt number AMADC–11104437 by Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts. (Attachments: # 1 Declaration of Alan Schoenfeld)(Hogue, Sharon) (Entered: 07/07/2025)
07/07/2025	8	MOTION for Leave to Appear Pro Hac Vice for admission of Albinas Prizgintas Filing fee: $ 125, receipt number AMADC–11104462 by Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts. (Attachments: # 1 Declaration of Albinas Prizgintas)(Hogue, Sharon) (Entered: 07/07/2025)
07/07/2025	9	MOTION for Leave to Appear Pro Hac Vice for admission of Cassandra Mitchell Filing fee: $ 125, receipt number AMADC–11104475 by Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts. (Attachments: # 1 Declaration of Cassandra Mitchell)(Hogue, Sharon) (Entered: 07/07/2025)
07/07/2025	10	MOTION for Leave to Appear Pro Hac Vice for admission of Alex W. Miller Filing fee: $ 125, receipt number AMADC–11104496 by Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts. (Attachments: # 1 Declaration of Alex W. Miller)(Hogue, Sharon) (Entered: 07/07/2025)
07/07/2025	11	MOTION for Leave to Appear Pro Hac Vice for admission of Jennifer Sandman Filing fee: $ 125, receipt number AMADC–11104533 by Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts. (Attachments: # 1 Declaration of Jennifer Sandman)(Hogue, Sharon) (Entered: 07/07/2025)
07/07/2025	12	MOTION for Leave to Appear Pro Hac Vice for admission of Emily Nestler Filing fee: $ 125, receipt number AMADC–11104556 by Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts. (Attachments: # 1 Declaration of Emily Nestler)(Hogue, Sharon) (Entered: 07/07/2025)
07/07/2025	13	MOTION for Leave to Appear Pro Hac Vice for admission of C. Peyton Humphreville Filing fee: $ 125, receipt number AMADC–11104566 by Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts. (Attachments: # 1 Declaration of C. Peyton Humphreville)(Hogue, Sharon) (Entered: 07/07/2025)
07/07/2025	14	MOTION for Leave to Appear Pro Hac Vice for admission of Kyla Eastling Filing fee: $ 125, receipt number AMADC–11104577 by Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts. (Attachments: # 1 Declaration of Kyla Eastling)(Hogue, Sharon) (Entered: 07/07/2025)
07/07/2025	15	ELECTRONIC NOTICE of Case Assignment. Judge Indira Talwani assigned to case. If the trial Judge issues an Order of Reference of any matter in this case to a Magistrate Judge, the matter will be transmitted to Magistrate Judge Jennifer C. Boal. (NMC) (Entered: 07/07/2025)
07/07/2025	16	Summons Issued as to Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, U.S. Department of Health and Human Services. **Counsel receiving this notice electronically should download this summons, complete one for each defendant and serve it in accordance with Fed.R.Civ.P. 4 and LR 4.1. Summons will be mailed to plaintiff(s) not receiving notice electronically for completion of service.** (SEC) (Entered: 07/07/2025)
07/07/2025	17	Judge Indira Talwani: ELECTRONIC ORDER granting *nunc pro tunc* Motion for Leave to File Excess Pages 3 . (SEC) (Entered: 07/07/2025)
07/07/2025	18	Judge Indira Talwani: TEMPORARY RESTRAINING ORDER. See attached. (SEC) (Entered: 07/07/2025)
07/07/2025	19	Judge Indira Talwani: ELECTRONIC ORDER: Defendants shall file any opposition to the Plaintiffs' request for a preliminary injunction, see Motion 4 , no later than July 14,

		2025. The clerk shall set a hearing on the motion for the morning of July 21, 2025. (SEC) (Entered: 07/07/2025)
07/07/2025	20	Judge Indira Talwani: ELECTRONIC ORDER entered granting 7 Motion for Leave to Appear Pro Hac Vice; granting 8 Motion for Leave to Appear Pro Hac Vice; granting 9 Motion for Leave to Appear Pro Hac Vice; granting 10 Motion for Leave to Appear Pro Hac Vice; granting 11 Motion for Leave to Appear Pro Hac Vice; granting 12 Motion for Leave to Appear Pro Hac Vice; granting 13 Motion for Leave to Appear Pro Hac Vice; granting 14 Motion for Leave to Appear Pro Hac Vice. Added Alan Schoenfeld, Albinas Prizgintas, Cassandra Mitchell, Alex W. Miller, Jennifer Sandman, Emily Nestler, C. Peyton Humphreville, and Kyla Eastling. **Attorneys admitted Pro Hac Vice must have an individual PACER account, not a shared firm account, to electronically file in the District of Massachusetts. To register for a PACER account, go the Pacer website at https://pacer.uscourts.gov/register-account. You must put the docket number under ADDITIONAL FILER INFORMATION on your form when registering or it will be rejected.** Pro Hac Vice Admission Request Instructions https://www.mad.uscourts.gov/caseinfo/nextgen-pro-hac-vice.htm. A Notice of Appearance must be entered on the docket by each of the newly admitted attorneys. (SEC) (Entered: 07/07/2025)
07/08/2025	21	ELECTRONIC NOTICE Setting Hearing on Motion 4 Emergency MOTION for Temporary Restraining Order *and Preliminary Injunction:* Motion Hearing set for 7/21/2025 11:00 AM in Courtroom 9 (In person only) before Judge Indira Talwani. (GAM) (Entered: 07/08/2025)
07/08/2025	22	NOTICE of Appearance by Alan E. Schoenfeld on behalf of Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts (Schoenfeld, Alan) (Entered: 07/08/2025)
07/08/2025	23	MOTION to Continue Hearing on Plaintiffs' Emergency Motion for a Temporary Restraining Order and Preliminary Injunction to July 24, 2025 by Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts.(Schoenfeld, Alan) (Entered: 07/08/2025)
07/09/2025	24	Opposition re 23 MOTION to Continue Hearing on Plaintiffs' Emergency Motion for a Temporary Restraining Order and Preliminary Injunction to July 24, 2025 filed by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, U.S. Department of Health and Human Services. (Neylan, Elisabeth) (Entered: 07/09/2025)
07/09/2025	25	Judge Indira Talwani: ELECTRONIC ORDER: Plaintiffs' Motion to Continue Hearing 23 seeks to continue the July 21, 2025 hearing on Plaintiffs' Motion for a Preliminary Injunction 4 , or in the alternative, to reschedule the hearing for July 18, 2025, based on Plaintiffs' counsel's schedule. Defendants request that the court deny Plaintiffs' Motion for lack of good cause to delay the hearing where Plaintiffs are represented by multiple counsel and where Defendants do not oppose Plaintiffs' remote attendance at the hearing. Defendants' Opp. 1-2 24 . Defendants note further that where a TRO has been entered, the hearing should be scheduled "at the earliest possible time," and that if the hearing is rescheduled, it should be set for July 17 or July 18, 2025, while maintaining existing briefing schedules. Id. (citing Fed. R. Civ. P. 65(b)(3)). Where both sides are available for an earlier hearing on July 18, 2025, the clerk shall reset the hearing on Plaintiffs' Motion for Preliminary Injunction 4 for the morning of July 18, 2025. Defendants' time to file an opposition to Plaintiffs' Motion for Preliminary Injunction 4 remains set for July 14, 2025. Plaintiffs' Motion to Continue Hearing 23 is denied as moot.(SEC) (Entered: 07/09/2025)

07/09/2025	26	ELECTRONIC NOTICE Resetting Hearing on Motion 4 Emergency MOTION for Temporary Restraining Order *and Preliminary Injunction* : Motion Hearing RESET for 7/18/2025 09:00 AM in Courtroom 9 (In person only) before Judge Indira Talwani. (SEC) (Entered: 07/09/2025)
07/09/2025	27	NOTICE of Appearance by Elisabeth Neylan on behalf of Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, U.S. Department of Health and Human Services (Neylan, Elisabeth) (Entered: 07/09/2025)
07/10/2025	28	NOTICE of Appearance by Elizabeth Themins Hedges on behalf of Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, U.S. Department of Health and Human Services (Hedges, Elizabeth) (Entered: 07/10/2025)
07/11/2025	29	MOTION to Vacate 18 Temporary Restraining Order *Motion to Dissolve* by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, U.S. Department of Health and Human Services. ~~(Attachments: # 1 Memorandum)~~(Hedges, Elizabeth) Memorandum in Support filed as own entry. See 30 (SEC). (Entered: 07/11/2025)
07/11/2025	30	MEMORANDUM in Support re 29 MOTION to Vacate 18 Temporary Restraining Order *Motion to Dissolve* filed by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, U.S. Department of Health and Human Services. (SEC) (Entered: 07/11/2025)
07/11/2025	31	NOTICE of Appearance by Thomas M. Harvey on behalf of American Center for Law & Justice (Harvey, Thomas) (Entered: 07/11/2025)
07/11/2025	32	MOTION for Leave to Appear Pro Hac Vice for admission of Nathan J. Moelker Filing fee: $ 125, receipt number AMADC–11117447 by American Center for Law & Justice.(Harvey, Thomas) (Entered: 07/11/2025)
07/11/2025	33	MOTION for Leave to Appear Pro Hac Vice for admission of Jordan A. Sekulow Filing fee: $ 125, receipt number AMADC–11117514 by American Center for Law & Justice. (Attachments: # 1 Exhibit amicus declaration)(Harvey, Thomas) (Entered: 07/11/2025)
07/11/2025	34	MOTION for Leave to Appear Pro Hac Vice for admission of Olivia F. Summers Filing fee: $ 125, receipt number AMADC–11117543 by American Center for Law & Justice. (Attachments: # 1 Exhibit amicus declaration)(Harvey, Thomas) (Entered: 07/11/2025)
07/11/2025	35	STATUS REPORT by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, U.S. Department of Health and Human Services. (Neylan, Elisabeth) (Entered: 07/11/2025)
07/11/2025	36	Assented to MOTION for Leave to File *Amicus Curiae Brief* by American Center for Law & Justice. (Attachments: # 1 Certificate of Compliance)(Harvey, Thomas) (Additional attachment(s) added on 7/11/2025: # 2 Proposed Amicus Brief) (SEC). (Entered: 07/11/2025)
07/11/2025	37	~~AMICUS BRIEF filed by American Center for Law & Justice . (Harvey, Thomas)~~ Proposed Amicus Brief filed as attachment to motion. See 36 –2 (SEC). (Entered: 07/11/2025)
07/11/2025	38	NOTICE of Appearance by Alexander Miller on behalf of Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts (Miller, Alexander) (Entered: 07/11/2025)
07/11/2025	39	NOTICE of Appearance by Albinas Prizgintas on behalf of Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts (Prizgintas, Albinas) (Entered: 07/11/2025)
07/11/2025	40	NOTICE of Appearance by Cassandra Mitchell on behalf of Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts (Mitchell, Cassandra) (Entered: 07/11/2025)
07/11/2025	41	Judge Indira Talwani: ELECTRONIC ORDER **allowing** 36 Assented to MOTION for Leave to File *Amicus Curiae Brief*.

		Counsel using the Electronic Case Filing System should now file the document for which leave to file has been granted in accordance with the CM/ECF Administrative Procedures. Counsel must include – Leave to file granted on (date of order)– in the caption of the document. (SEC) (Entered: 07/11/2025)
07/11/2025	42	Judge Indira Talwani: ELECTRONIC ORDER entered granting 32 Motion for Leave to Appear Pro Hac Vice; granting 33 Motion for Leave to Appear Pro Hac Vice; granting 34 Motion for Leave to Appear Pro Hac Vice. Added Nathan J. Moelker, Jordan A. Sekulow, and Olivia F. Summers. **Attorneys admitted Pro Hac Vice must have an individual PACER account, not a shared firm account, to electronically file in the District of Massachusetts. To register for a PACER account, go the Pacer website at https://pacer.uscourts.gov/register–account. You must put the docket number under ADDITIONAL FILER INFORMATION on your form when registering or it will be rejected.** Pro Hac Vice Admission Request Instructions https://www.mad.uscourts.gov/caseinfo/nextgen–pro–hac–vice.htm. A Notice of Appearance must be entered on the docket by each of the newly admitted attorneys. (SEC) (Entered: 07/11/2025)
07/11/2025	43	NOTICE of Appearance by Olivia F. Summers on behalf of American Center for Law & Justice (Summers, Olivia) (Entered: 07/11/2025)
07/11/2025	44	AMICUS BRIEF filed by American Center for Law & Justice . (Summers, Olivia) (Entered: 07/11/2025)
07/11/2025	45	NOTICE of Appearance by Nathan Jeremiah Moelker on behalf of American Center for Law & Justice (Moelker, Nathan) (Entered: 07/11/2025)
07/11/2025	46	Judge Indira Talwani: ORDER entered on Defendants' Motion to Vacate 29 . The court dissolves the Temporary Restraining Order 18 issued on July 7, 2025, and enters this AmendedTemporary Restraining Order for the reasons set forth therein. See attached Amended Temporary Restraining Order. (Talwani, Indira) (Entered: 07/11/2025)
07/13/2025	47	NOTICE of Appearance by Emily Margaret Hall on behalf of Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, U.S. Department of Health and Human Services (Hall, Emily) (Entered: 07/13/2025)
07/14/2025	48	NOTICE of Appearance by C. Peyton Humphreville on behalf of Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts (Humphreville, C. Peyton) (Entered: 07/14/2025)
07/14/2025	49	MOTION for Leave to File Excess Pages by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, U.S. Department of Health and Human Services.(Neylan, Elisabeth) (Entered: 07/14/2025)
07/14/2025	50	NOTICE of Appearance by C. Peyton Humphreville on behalf of Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts (Humphreville, C. Peyton) (Entered: 07/14/2025)
07/14/2025	51	Judge Indira Talwani: ELECTRONIC ORDER **allowing** 49 MOTION for Leave to File Excess Pages; Counsel using the Electronic Case Filing System should now file the document for which leave to file has been granted in accordance with the CM/ECF Administrative Procedures. Counsel must include – Leave to file granted on (date of order)– in the caption of the document. (SEC) (Entered: 07/14/2025)
07/14/2025	52	NOTICE of Appearance by Jennifer Sandman on behalf of Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts (Sandman, Jennifer) (Entered: 07/14/2025)

07/14/2025	53	MEMORANDUM in Opposition re 4 Emergency MOTION for Temporary Restraining Order *and Preliminary Injunction* filed by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, U.S. Department of Health and Human Services. (Attachments: # 1 Affidavit Costello Declaration, # 2 Affidavit Snyder Declaration)(Neylan, Elisabeth) Modified on 7/15/2025 to correct heading error (SEC). (Entered: 07/14/2025)
07/15/2025	54	NOTICE of Appearance by Jordan A. Sekulow on behalf of American Center for Law & Justice (Sekulow, Jordan) (Entered: 07/15/2025)
07/15/2025	55	NOTICE by Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts *of Undertaking on Temporary Restraining Order* (Schoenfeld, Alan) (Entered: 07/15/2025)
07/15/2025	56	NOTICE of Appearance by Emily Nestler on behalf of Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts (Nestler, Emily) (Entered: 07/15/2025)
07/16/2025	57	NOTICE of Appearance by Kyla Eastling on behalf of Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts (Eastling, Kyla) (Entered: 07/16/2025)
07/17/2025	58	MOTION for Leave to File *a Reply in Support of Motion for Preliminary Injunction* by Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts. (Attachments: # 1 Exhibit A – Plaintiffs' Proposed Reply, # 2 Exhibit 1)(Schoenfeld, Alan) (Entered: 07/17/2025)
07/17/2025	59	Judge Indira Talwani: ELECTRONIC ORDER **allowing** 58 MOTION for Leave to File a Reply in Support of Motion for Preliminary Injunction. Counsel using the Electronic Case Filing System should now file the document for which leave to file has been granted in accordance with the CM/ECF Administrative Procedures. Counsel must include – Leave to file granted on (date of order)– in the caption of the document. (SEC) (Entered: 07/17/2025)
07/17/2025	60	REPLY to Response to 4 Emergency MOTION for Temporary Restraining Order *and Preliminary Injunction* filed by Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts. (Attachments: # 1 Exhibit 1)(Schoenfeld, Alan) (Entered: 07/17/2025)
07/18/2025	61	Electronic Clerk's Notes for proceedings held before Judge Indira Talwani: Motion Hearing held on 7/18/2025 re 4 Emergency MOTION for Temporary Restraining Order *and Preliminary Injunction* filed by Planned Parenthood League of Massachusetts, Planned Parenthood Federation of America, Inc., Planned Parenthood Association of Utah. Case called. Court heard argument from counsel. Order to issue by 7/21/2025. (Court Reporter: Robert Paschal at rwp.reporter@gmail.com.)(Attorneys present: Kyla Eastling, Sharon Hogue, C. Peyton Humphreville, Alexander Miller, Emily Nestler, Albinas Prizgintas, Alan E. Schoenfeld, Emily Margaret Hall, Elizabeth Themins Hedges) (GAM) (Entered: 07/18/2025)
07/21/2025	62	Judge Indira Talwani: Plaintiffs' Emergency Motion for a Preliminary Injunction [Doc. No. 4] is GRANTED in part and otherwise remains under advisement. See attached Memorandum and Order. (Talwani, Indira) (Entered: 07/21/2025)
07/22/2025	63	NOTICE OF APPEAL as to 62 Order on Motion for TRO by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, U.S. Department of Health and Human Services. Fee Status: US Government. NOTICE TO COUNSEL: A Transcript Report/Order Form, which can be downloaded from the First Circuit Court of Appeals web site at http://www.ca1.uscourts.gov MUST be completed and submitted to the Court of Appeals. **Counsel shall register for a First Circuit CM/ECF Appellate Filer Account at http://pacer.psc.uscourts.gov/cmecf. Counsel shall also review the First Circuit**

		requirements for electronic filing by visiting the CM/ECF Information section at http://www.ca1.uscourts.gov/cmecf. US District Court Clerk to deliver official record to Court of Appeals by 8/11/2025. (Hall, Emily) (Entered: 07/22/2025)
07/22/2025	64	Certified and Transmitted Abbreviated Electronic Record on Appeal to US Court of Appeals re 63 Notice of Appeal. (MAP) (Entered: 07/22/2025)
07/23/2025	65	USCA Case Number 25–1698 for 63 Notice of Appeal, filed by Robert F. Kennedy, Jr., Centers for Medicare & Medicaid Services, Mehmet Oz, U.S. Department of Health and Human Services. (MAP) (Entered: 07/23/2025)
07/23/2025	66	Emergency MOTION for Clarification *of the Court's July 21, 2025 Order or, in the Alternative, to Extend Amended Temporary Restraining Order* by Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts.(Schoenfeld, Alan) (Entered: 07/23/2025)
07/23/2025	67	MEMORANDUM in Support re 66 Emergency MOTION for Clarification *of the Court's July 21, 2025 Order or, in the Alternative, to Extend Amended Temporary Restraining Order* filed by Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts. (Schoenfeld, Alan) (Entered: 07/23/2025)
07/24/2025	68	NOTICE by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, U.S. Department of Health and Human Services *of Intent to Oppose Pls.' Motion for Clarification, ECF Nos. 66, 67*. (Neylan, Elisabeth) (Entered: 07/24/2025)
07/28/2025	69	Judge Indira Talwani: ELECTRONIC ORDER granting Plaintiffs' Motion for a Preliminary Injunction 4 . See attached Memorandum and Order. (SEC) (Entered: 07/28/2025)
07/28/2025	70	Transcript of Motion Hearing held on July 18, 2025, before Judge Indira Talwani. COA Case No. 25–1698. The Transcript may be purchased through the Court Reporter, viewed at the public terminal, or viewed through PACER after it is released. Court Reporter Name and Contact Information: Robert Paschal at rwp.reporter@gmail.com. Redaction Request due 8/18/2025. Redacted Transcript Deadline set for 8/28/2025. Release of Transcript Restriction set for 10/27/2025. (DRK) (Entered: 07/29/2025)
07/29/2025	71	NOTICE is hereby given that an official transcript of a proceeding has been filed by the court reporter in the above–captioned matter. Counsel are referred to the Court's Transcript Redaction Policy, available on the court website at https://www.mad.uscourts.gov/caseinfo/transcripts.htm (DRK) (Entered: 07/29/2025)
07/29/2025	72	Judge Indira Talwani: ELECTRONIC ORDER denying without prejudice Plaintiffs' Emergency Motion for Clarification of the Court's July 21, 2025 Order or, in the Alternative, to Extend Amended Temporary Restraining Order 66 . Any renewed Motion for Clarification should be directed at this court's July 28, 2025 Memorandum & Order 69 , rather than the July 21, 2025 Memorandum & Order 62 . (SEC) (Entered: 07/29/2025)
08/04/2025	73	Joint MOTION for Clarification , *or in the Alternative*, MOTION for Extension of Time to August 11, 2025 to Submit a Proposed Case Schedule, or Move to Extend Such Deadline (Responses due by 8/18/2025) by Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts.(Schoenfeld, Alan) (Entered: 08/04/2025)
08/05/2025	74	Judge Indira Talwani: ELECTRONIC ORDER granting Joint Motion to Clarify, or in the Alternative to Extend, Deadline to Submit Case Schedule 73 . The parties shall submit a proposed case schedule by August 11, 2025. (SEC) (Entered: 08/05/2025)
08/05/2025	75	NOTICE OF APPEAL as to 69 Memorandum & ORDER by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, U.S. Department of Health and Human Services. Fee Status: US Government. NOTICE TO COUNSEL: A Transcript Report/Order Form, which can be downloaded from the First Circuit Court of Appeals web site at http://www.ca1.uscourts.gov MUST be completed and submitted to the Court of Appeals. **Counsel shall register for a First Circuit CM/ECF Appellate Filer Account at**

		http://pacer.psc.uscourts.gov/cmecf. Counsel shall also review the First Circuit requirements for electronic filing by visiting the CM/ECF Information section at http://www.ca1.uscourts.gov/cmecf. US District Court Clerk to deliver official record to Court of Appeals by 8/25/2025. (Neylan, Elisabeth) (Entered: 08/05/2025)
08/05/2025	76	Certified and Transmitted Abbreviated Electronic Record on Appeal to US Court of Appeals re 75 Notice of Appeal. (MAP) (Entered: 08/05/2025)
08/05/2025	77	SUMMONS Returned Executed Mehmet Oz served on 7/10/2025, answer due 7/31/2025. (Schoenfeld, Alan) (Entered: 08/05/2025)
08/05/2025	78	SUMMONS Returned Executed Centers for Medicare & Medicaid Services served on 7/10/2025, answer due 7/31/2025. (Schoenfeld, Alan) (Entered: 08/05/2025)
08/05/2025	79	SUMMONS Returned Executed U.S. Department of Health and Human Services served on 7/10/2025, answer due 7/31/2025. (Schoenfeld, Alan) (Entered: 08/05/2025)
08/05/2025	80	SUMMONS Returned Executed Robert F. Kennedy, Jr served on 7/10/2025, answer due 7/31/2025. (Schoenfeld, Alan) (Entered: 08/05/2025)
08/05/2025	81	SUMMONS Returned Executed by Planned Parenthood Association of Utah, Planned Parenthood League of Massachusetts, Planned Parenthood Federation of America, Inc.. (Schoenfeld, Alan) (Entered: 08/05/2025)
08/05/2025	82	SUMMONS Returned Executed as to US Attorney by Planned Parenthood Association of Utah, Planned Parenthood League of Massachusetts, Planned Parenthood Federation of America, Inc.. (Schoenfeld, Alan) (Entered: 08/05/2025)
08/07/2025	83	USCA Case Number 25–1755 for 75 Notice of Appeal, filed by Robert F. Kennedy, Jr., Centers for Medicare & Medicaid Services, Mehmet Oz, U.S. Department of Health and Human Services. (MAP) (Entered: 08/07/2025)
08/07/2025	84	MOTION to Stay re 62 Order on Motion for TRO, 69 Memorandum & ORDER by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, U.S. Department of Health and Human Services.(Neylan, Elisabeth) (Entered: 08/07/2025)
08/07/2025	85	MEMORANDUM in Support re 84 MOTION to Stay re 62 Order on Motion for TRO, 69 Memorandum & ORDER filed by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, U.S. Department of Health and Human Services. (Neylan, Elisabeth) (Entered: 08/07/2025)
08/11/2025	86	Joint MOTION to Stay *Further District Court Proceedings Pending Resolution of the Government's Motion to Stay Preliminary Injunctions Pending Appeal* by Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts.(Schoenfeld, Alan) (Entered: 08/11/2025)
08/11/2025	87	Judge Indira Talwani: ELECTRONIC ORDER entered. On July 21, 2025, the court granted in part Plaintiffs' Emergency Motion for a Preliminary Injunction [Doc. No. 4], enjoining Defendants from enforcing the provisions of Section 71113 of "An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14" against Planned Parenthood Association of Utah and other Planned Parenthood Federation of America Members who will not provide abortion services as of October 1, 2025, or for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act for medical assistance furnished in fiscal year 2023 made directly to them did not exceed $800,000. Mem. & Order 35 [Doc. No. 62]. At the same time, the court considered and denied Defendants' request, see Defs.' Mem. 44 [Doc. No. 53], that any injunctive relief be stayed pending appeal, Mem. & Order 33–35 [Doc. No. 62]. Defendants filed an appeal the following day, see Notice of Appeal [Doc. No. 63], but did not seek a stay from the First Circuit. On July 28, 2025, the court granted Plaintiffs' Emergency Motion for a Preliminary Injunction [Doc. No. 4] in full, enjoining Defendants from enforcing the provisions of Section 71113 of "An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14" against Planned Parenthood Association of Utah, Planned Parenthood League of Massachusetts, and all other Planned Parenthood Federation of America Members. Mem. & Order 57–58 [Doc. No. 69]. The court again considered and denied

		Defendants' request, see Defs.' Mem. 44 [Doc. No. 53], that any injunctive relief be stayed pending appeal. Mem. & Order 56–57 [Doc. No. 69]. Defendants filed an appeal eight days later, on August 5, 2025, see Notice of Appeal [Doc. No. 75], but have not sought a stay from the First Circuit to date. On August 7, 2025, after filing their second Notice of Appeal [Doc. No. 75], Defendants filed a stand–alone Motion to Stay Preliminary Injunctions Pending Appeal [Doc. No. 84] in this court. Defendants acknowledge that they had previously requested a stay and that the court had denied the request, see Mem. in Support 2 [Doc. No. 85] (citing Defs.' Mem. at 44 [Doc. No. 53] (requesting stay pending appeal); Mem. & Order 33–35 [Doc. No. 62] (denying stay request); Mem. & Order 56–57 [Doc. No. 69] (denying stay request)). Defendants explain their further filing by citing Am. Pub. Health Assn v. Nat'l Institutes of Health, –– F.4th––, 2025 WL 2017106, at *8 (1st Cir. July 18, 2025) (requiring the government to raise all arguments in support of stay pending appeal in its stay motion). Defendants also "request[] a ruling on this motion by this Monday, August 11, 2025, so that [Defendants] may promptly request relief from the First Circuit, if necessary." Mem. in Support 2–3 [Doc. No. 85]. But the court has already ensured that Defendants could immediately seek relief from the First Circuit by acting on their previous request for a stay at the same time that the court addressed Plaintiffs' Emergency Motion for a Preliminary Injunction [Doc. No. 4]. In light of that, Defendants' belated concern about presenting all arguments to this court does not justify an expedited ruling on Defendants' request for reconsideration. Plaintiffs shall file their response to Defendants' Motion to Stay [Doc. No. 84] no later than August 21, 2025. The court anticipates considering Defendants' Motion [Doc. No. 84] promptly once Plaintiffs have filed their response.(Talwani, Indira) (Entered: 08/11/2025)
08/13/2025	88	Judge Indira Talwani: ELECTRONIC ORDER granting Joint Motion to Stay Further District Court Proceedings 86 . Good cause shown, the court stays further proceedings in this court, except as to Defendants' Motion to Stay Preliminary Injunctions Pending Appeal 84 , pending resolution of that motion and any similar motion made on appeal. Plaintiffs' deadline to submit any response to Defendants' Motion 84 remains August 21, 2025, in accordance with the court's previous Electronic Order 87 . (SEC) (Entered: 08/13/2025)
08/19/2025	89	ORDER of USCA as to 63 Notice of Appeal filed by Robert F. Kennedy, Jr., Centers for Medicare & Medicaid Services, Mehmet Oz, U.S. Department of Health and Human Services and 75 Notice of Appeal filed by Robert F. Kennedy, Jr., Centers for Medicare & Medicaid Services, Mehmet Oz, U.S. Department of Health and Human Services. (JAM) Modified on 9/1/2025 to Correct Filing Date. (MAP). (Entered: 08/20/2025)
08/20/2025	90	NOTICE by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, U.S. Department of Health and Human Services re 85 Memorandum in Support of Motion, 84 MOTION to Stay re 62 Order on Motion for TRO, 69 Memorandum & ORDER (Neylan, Elisabeth) (Entered: 08/20/2025)
08/20/2025	91	NOTICE by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, U.S. Department of Health and Human Services re 85 Memorandum in Support of Motion, 84 MOTION to Stay re 62 Order on Motion for TRO, 69 Memorandum & ORDER (Neylan, Elisabeth) (Entered: 08/20/2025)
08/21/2025	92	Opposition re 84 MOTION to Stay re 62 Order on Motion for TRO, 69 Memorandum & ORDER filed by Planned Parenthood Association of Utah, Planned Parenthood Federation of America, Inc., Planned Parenthood League of Massachusetts. (Schoenfeld, Alan) (Entered: 08/21/2025)
08/29/2025	93	Judge Indira Talwani MEMORANDUM AND ORDER: For the reasons set forth in the attached document, Defendants' Motion [Doc. No. 84] is DENIED. (GAM) (Entered: 08/29/2025)
09/11/2025	94	ORDER of USCA as to 75 Notice of Appeal, filed by Robert F. Kennedy, Jr., Centers for Medicare & Medicaid Services, Mehmet Oz, U.S. Department of Health and

		Human Services, 63 Notice of Appeal, filed by Robert F. Kennedy, Jr., Centers for Medicare & Medicaid Services, Mehmet Oz, U.S. Department of Health and Human Services (MAP) **ORDER entered by Gustavo A. Gelp, Jr., Appellate Judge; Lara E. Montecalvo, Appellate Judge; and Seth Robert Aframe, Appellate Judge: On July 21, 2025, the district court preliminarily enjoined the defendants in this action –– the Department of Health and Human Services and its Secretary, along with the Centers for Medicare and Medicaid Services and the Administrator –– from "enforcing, retroactively enforcing, or otherwise applying" section 71113 of the Act of July 4, 2025, Pub. L. No. 119–21, § 71113, 139 Stat. 72, 300–01 (2025), against plaintiff Planned Parenthood Association of Utah and other members of plaintiff Planned Parenthood Federation of America, Inc., who met certain conditions specified in the court's order. The preliminary injunction also ordered the defendants to "take all steps necessary to ensure that Medicaid funding continues to be disbursed in the customary manner and timeframes to Planned Parenthood Association of Utah and other Planned Parenthood Federation of America [m]embers" who satisfied the specified conditions. The defendants have appealed both injunctions. We denied without prejudice as premature the defendants' motion to stay the injunctions pending the disposition of those appeals, while a motion for similar relief was pending in the district court. Notwithstanding the contrary conclusion reached by the district court after its careful consideration of the matter, we conclude that defendants have met their burden to show their entitlement to a stay of the preliminary injunctions pending the disposition of their appeals of the same. The motion is GRANTED. The July 21, 2025 preliminary injunction and the July 28, 2025 preliminary injunction are hereby stayed pending disposition of the respective appeals. The separate motions by the State of Louisiana and the American Center for Law & Justice for leave to file an amicus brief also are GRANTED and the briefs are accepted for filing as of this date. So ordered.** (Entered: 09/11/2025)
09/12/2025	95	Judge Indira Talwani: ELECTRONIC ORDER: On August 13, 2025, at the parties' joint request, the court stayed proceedings in this court pending resolution of Defendants' Motion to Stay Preliminary Injunctions Pending Appeal 84 "and any similar motion made on appeal." Elec. Order 88 . Where the First Circuit has now resolved Defendants' Motion to Stay Preliminary Injunctions, see Order 94 , the stay of the proceedings in this court is lifted. The parties shall submit a proposed case schedule no later than September 26, 2025. (SEC) (Entered: 09/12/2025)
09/23/2025	96	Joint MOTION to Stay *Further District Court Proceedings Pending Resolution of Expedited Appeal of This Court's Preliminary Injunctions* by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, U.S. Department of Health and Human Services.(Neylan, Elisabeth) (Entered: 09/23/2025)
09/24/2025	97	Judge Indira Talwani: ELECTRONIC ORDER granting Joint Motion to Stay Further District Court Proceedings Pending Resolution of Expedited Appeal 96 . Good cause shown, the court stays further proceedings in this court pending resolution of Defendants' appeal of this court's July 21, 2025 Memorandum and Order 62 , and this court's July 28, 2025 Memorandum and Order 69 , to the First Circuit. (SEC) (Entered: 09/24/2025)

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.; PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS; and PLANNED PARENTHOOD ASSOCIATION OF UTAH, Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; MEHMET OZ, in his official capacity as ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES; and CENTERS FOR MEDICARE & MEDICAID SERVICES, Defendants.	Case No. 1:25-cv-11913

COMPLAINT FOR
DECLARATORY AND INJUNCTIVE RELIEF

Plaintiffs Planned Parenthood Federation of America, Inc., on behalf of itself and all 47 of its members, as well as two of those members, Planned Parenthood League of Massachusetts and Planned Parenthood Association of Utah, allege in support of their Complaint for Declaratory and Injunctive Relief as follows:

NATURE OF THE ACTION

1. This is a challenge to Section 71113 of An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14 (the "Defund Provision"),[1] to vindicate rights secured by the Constitution's Bill of Attainder Clause and by the First and Fifth Amendments to the United States Constitution.

2. The clear purpose of the Defund Provision is to categorically prohibit health centers associated with Planned Parenthood from receiving Medicaid reimbursements. The prohibition specifically targets Planned Parenthood Federation of America ("PPFA") and its member health care providers (collectively, the "Members" and each individually, a "Member") in order to punish them for lawful activity, namely advocating for and providing legal abortion access wholly outside the Medicaid program and without using any federal funds.

3. Anti-abortion politicians have targeted PPFA and its Members (collectively, "Planned Parenthood") for decades, and the history and context of the Defund Provision underscores that the purpose of this law is to punish Planned Parenthood by blocking its Members from providing and being reimbursed for care through the Medicaid program. The Defund Provision targets Planned Parenthood Member providers by expressly limiting its application to abortion providers that are non-profits that primarily provide family planning services, and

[1] *Available at* https://www.congress.gov/bill/119th-congress/house-bill/1/text.

received more than $800,000 in Medicaid reimbursements in fiscal year 2023—a set made up almost entirely of Planned Parenthood Members. And if there were any doubt, President Trump, Speaker Johnson, and their allies have been promising to "defund Planned Parenthood" for years now. That is what the Defund Provision does.

4. If allowed to take effect and prevent Planned Parenthood Members from providing care to the almost 80 million Americans who rely on Medicaid for their essential health care needs, the Defund Provision will have devastating consequences nationwide.

5. With a history going back over 100 years, PPFA and its 47 independent Members play an essential role in the delivery of health care to millions of people in the United States. Planned Parenthood envisions a world of equity: where sexual and reproductive rights are basic human rights, where access to health care does not depend on who you are, where you live, or your ability to pay, and where every person has the opportunity to choose their own path to a healthy and meaningful life. All Planned Parenthood organizations are driven by this mission to ensure access to sexual and reproductive health care and rights, including abortion care.

6. As detailed below, Planned Parenthood Members are at the forefront of providing high-quality reproductive health care to individuals and communities facing serious barriers to obtaining such care—especially individuals with low incomes, individuals in rural and other medically underserved areas, and individuals of color. Planned Parenthood Members operate nearly 600 health centers across the Nation and serve over 2,000,000 patients each year, providing vital health care services such as contraception, cancer screenings, testing and treatment for sexually transmitted infections ("STIs"), gender-affirming hormone therapy, and abortion services.

7. Planned Parenthood Members have been a critical part of the Medicaid program for decades, providing preventive and life-saving health care to eligible low-income patients across the nation. More than 1,000,000 patients each year receive health care services at Planned Parenthood Member health centers through Medicaid. Consistent with their mission-driven commitment to provide high-quality sexual and reproductive health care to all people, regardless of their ability to pay, no Planned Parenthood Member limits the number of Medicaid patients it will treat.[2] At a time when low reimbursement rates lead many health care providers to either effectively limit the number of Medicaid patients they serve or not participate in Medicaid at all, in many communities, a Planned Parenthood Member health center is the only place where individuals can receive sexual and reproductive health care services through the Medicaid program. For this reason, losing the ability to choose a Planned Parenthood Member health center as their Medicaid provider will be devastating for Medicaid patients across the country.

8. If the Defund Provision is not enjoined, the consequences will be catastrophic for Planned Parenthood Members, each of which is a non-profit health care provider with a mission of ensuring that every person has access to sexual and reproductive health care and education, and as a result will harm health care access among non-Medicaid patients too. More than 50% of Planned Parenthood Member patients rely on Medicaid to access essential health services. In federal fiscal year 2023, more than one-third of Members' total aggregate revenue was from Medicaid reimbursement for health care services the Members provided. Because of the great unmet need for high-quality Medicaid providers of sexual and reproductive health care, some of

[2] Planned Parenthood Members participate in Medicaid programs in every state where they are able, a total of forty-six of forty-seven Members across forty-three states.

those Members received the vast majority (over three quarters) of their health services revenue from Medicaid reimbursements that year. Stripping away this patient volume and reimbursements for care provided will result in the elimination of services, laying off staff, and health center closures. The public health consequences for Medicaid patients and non-Medicaid patients alike will be dire and compounding.

9. The Defund Provision emphatically does *not* address federal funding for abortion. For more than four decades, federal law has prohibited health care providers from using federal funds for abortions (subject to extremely narrow exceptions) and that has been true for the entirety of Planned Parenthood Members' participation in Medicaid. Thus, this statute must be doing something more—and it is. The Defund Provision is a naked attempt to leverage the government's spending power to attack and penalize Planned Parenthood and impermissibly single it out for unfavorable treatment. It does so not only because of Planned Parenthood Members' long history of providing legal abortions to patients across the country, but also because of Planned Parenthood's unique role in advocating for policies to protect and expand access to sexual and reproductive health care, including abortion.

10. There is no legitimate justification for the statute; rather, the true design of the Defund Provision is simply to express disapproval of, attack, and punish Planned Parenthood, which plays a particularly prominent role in the public debate over abortion and (if Planned Parenthood's Members are treated collectively) is the only nationwide abortion provider. Supporters of the Defund Provision, including President Trump and members of Congress, have made this point unmistakably clear.

11. For these reasons, the Defund Provision's exclusion of Planned Parenthood Members from a program designed to provide high-quality medical care to the Nation's neediest patients—care that Planned Parenthood Members have delivered for decades—is unconstitutional as to all Planned Parenthood Members as a Bill of Attainder and it also violates Plaintiffs' Equal Protection and First Amendment rights.

12. In the alternative, if the Defund Provision is allowed to remain in effect as to any Planned Parenthood Member, it should be held not to apply to those Members who do not independently meet each of the required statutory triggers for defunding. It is clear that Congress intended to punish Planned Parenthood Members for their unique role in providing abortions and to defund *all* entities associated with Planned Parenthood for their participation in a visible and unique membership association with a shared mission of abortion advocacy. However, the enacted language is actually more narrow, likely because Congress misunderstood Planned Parenthood's structure. By its terms, the Defund Provision applies only to entities that meet the statutory requirements for being a "prohibited entity" and entities that have a relationship of ownership or control with those "prohibited entit[ies]." No such relationship exists between PPFA and any of its Members. Indeed, if not construed this way, the Defund Provision is an unconstitutional attack on the associational rights of those Planned Parenthood Members who do not independently meet the trigger, by forbidding them from being reimbursed for Medicaid care based solely on their association with other Planned Parenthood Members providers despite a lack of any relationship of ownership or control. At best, the Defund Provision is unconstitutionally vague as applied to those Members on this point, and they will have no choice but to stop seeking Medicaid

reimbursement absent direction from the Court, lest they otherwise face the untenable risk of arbitrary enforcement.

13. If not enjoined, the Defund Provision will devastate Planned Parenthood Members, their patients, and the broader public health of the Nation. If allowed to take effect and construed to apply to all Members, the Defund Provision will jeopardize care for the more than 1,000,000 patients per year who receive care from Planned Parenthood Members through the Medicaid program—with many of those patients losing access to health care altogether. Many Planned Parenthood Members will be required to lay off staff and curtail services, with serious adverse consequences for the many patients served at those centers even if they do not use Medicaid to access services. Worse still, Members may be forced to shutter a substantial number of their health centers nationwide, many of which are in rural or underserved areas without alternative providers. And even where alternative providers are theoretically available, those providers, who are already stretched to capacity, often do not offer the same comprehensive sexual and reproductive health service options, have long wait times for patients, and cannot accommodate the huge influx of patients who would need to find a new provider of care.

14. The adverse public health consequences of the Defund Provision will be grave. The elimination or reduction in access to sexual and reproductive health care across the Nation is likely to lead to increased rates of undiagnosed and untreated STIs and cancer, as well as increased rates of unplanned pregnancies and abortions. Moreover, individuals with low incomes, who live in medically underserved or rural areas, and who are Black, Latinx, or members of other communities of color will disproportionately feel those consequences.

15. Thus, to remedy the multiple violations of their constitutional rights and to prevent irreparable harm to themselves and to the millions of individuals whose health care would be jeopardized, Plaintiffs seek declaratory and injunctive relief to prevent the Defund Provision from remaining in effect. In the alternative, Plaintiffs seek declaratory and injunctive relief to ensure that Planned Parenthood Members that do not independently qualify as "prohibited entit[ies]" under the statute are able to continue submitting and receiving Medicaid reimbursements.

JURISDICTION AND VENUE

16. This Court has jurisdiction over this action under 28 U.S.C. § 1331 and 5 U.S.C. § 702. *Commonwealth of Puerto Rico v. United States*, 490 F.3d 50, 57-58 (1st Cir. 2007); *Trudeau v. Fed. Trade Comm'n*, 456 F.3d 178, 186 (D.C. Cir. 2006).

17. The Court is authorized to issue the relief sought here under the Declaratory Judgment Act, 28 U.S.C. §§ 2201-2202, Rules 57 and 65 of the Federal Rules of Civil Procedure, and the inherent equitable powers of this Court. This Court has inherent equitable power to enjoin executive conduct that violates the Constitution. *See Free Enter. Fund v. Pub. Co. Acct. Oversight Bd.*, 561 U.S. 477, 491 n.2 (2010); *Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320, 326-27 (2015) (noting that federal courts possess the power in equity to grant injunctive relief "with respect to violations of federal law by federal officials").

18. Venue in this judicial district is proper under 28 U.S.C. § 1391(e). Plaintiff Planned Parenthood League of Massachusetts ("PPLM") resides in this district, and a substantial part of the events or omissions giving rise to this action occurred in this district. PPLM is headquartered in Boston, Massachusetts; it operates four health centers—in Boston, Worcester, Marlborough,

and Springfield—that participate in the Medicaid program but which are barred from receiving federal Medicaid reimbursements under the Defund Provision.

PARTIES TO THE ACTION

19. **Plaintiff Planned Parenthood Federation of America** is a 501(c)(3) not-for-profit corporation organized under the laws of New York. PPFA is a membership organization with 47 Members that have health centers in 47 states and the District of Columbia, as well as a telehealth presence in all 50 States. PPFA and its Members share a mission of ensuring that regardless of income, insurance, gender identity, sexual orientation, or race, people can receive high-quality, inclusive, and comprehensive sexual and reproductive health care. PPFA does not itself provide any health care but provides support to 47 Members that do, as explained below.

20. Planned Parenthood Members provide medical services through nearly 600 health centers across the nation and serve millions of people each year by providing a wide range of sexual and reproductive health care, as well as other care. An estimated one out of every three women and one in ten men nationally has received care from a Planned Parenthood Member at least once in their life.

21. PPFA and its Members, along with national, state, and local Planned Parenthood 501(c)(4) social welfare organizations, have long been at the forefront of the movement for sexual and reproductive rights, advocating at the federal, state, and local levels to expand abortion access. As the nation's leading advocates for sexual and reproductive health care and education, Planned Parenthood organizations advocate at the federal, state, and local levels to protect and expand access to services and information. This includes pushing to codify the rights to abortion and contraception, block abortion bans, repeal the Hyde Amendment, and ensure access to emergency

contraception and medication abortion. Planned Parenthood Action Fund, a related 501(c)(4) organization, seeks to hold members of Congress politically accountable through its congressional scorecard, communicating with and activating constituents to educate their lawmakers about the importance of sexual and reproductive health care. Planned Parenthood Members and their related 501(c)(4) organizations play a similar role in state legislatures across the nation. Since the Supreme Court's ruling in *Dobbs*, Planned Parenthood Action Fund and Members' related 501(c)(4) organizations have actively supported successful campaigns for reproductive freedom ballot initiatives. Separately, Planned Parenthood Action Fund and other national and local Planned Parenthood advocacy and political organizations work to elect federal, state, and local officials who will support reproductive freedom and abortion access. Planned Parenthood Members, and when appropriate PPFA, are active litigants fighting to secure abortion access and rights for their patients in federal and state courts across the country.

22. PPFA and its Members provide education and information to Members' patients and the general public about sexual and reproductive health, risks, and preventive measures, reaching approximately 1.3 million individuals in person with education and information in their communities—and even more people online. Planned Parenthood Member educators also train teachers, school staff, and other youth-serving professionals within their communities on critical topics such as age-appropriate youth pregnancy prevention and STI prevention.

23. PPFA sues on behalf of itself and all of its Members. By excluding Planned Parenthood Members from Medicaid reimbursements, the Defund Provision injures PPFA. Patients have come to know and trust the Planned Parenthood name, and understand that they can count on Planned Parenthood Members for some of their most sensitive health care needs. The

exclusion will force its Members to abruptly withdraw care from patients who depend on Medicaid—that is, more than half of all Planned Parenthood Member patients—and compel the closure of health centers on which patients depend. Not only will this harm the Planned Parenthood name and reputation, but ultimately, the exclusion strikes at PPFA's and its Members' shared mission of ensuring the provision of sexual and reproductive care, including abortion care, providing related educational services, promoting research on sexual and reproductive health, and advocating for public policies that guarantee access to such services. All of these injuries stem from the enforcement of the Defund Provision, and all are redressable by a judicial declaration and injunction. PPFA therefore has standing in its own right to challenge the exclusion, which drains the organization's resources and impairs its ability to carry out its mission. *See Republican Nat'l Comm. v. N.C. State Bd. of Elections*, 120 F.4th 390, 395-98 (4th Cir. 2024).

24. PPFA also has standing on behalf of its Members who participate in the Medicaid program because (1) its Members would otherwise have standing to sue in their own right; (2) the interests PPFA seeks to protect are germane to its purposes; and (3) neither the claims asserted, nor the relief requested, requires the participation in this lawsuit of each individual Planned Parenthood Member.

25. **Plaintiff Planned Parenthood League of Massachusetts** is a 501(c)(3) not-for-profit corporation organized under the laws of the Commonwealth of Massachusetts. Its principal office is in Boston, Massachusetts. PPLM operates four health centers in Massachusetts in Boston, Worcester, Marlborough, and Springfield; and a virtual health center that offers telehealth services via phone and video.

26. PPLM is a separately incorporated, independently operated organization and a Planned Parenthood Member.

27. PPLM delivers health care to more than 30,000 patients each year. In 2024, PPLM provided patients with more than 20,500 birth control methods, including nearly 5,000 long-acting reversible contraceptives ("LARCs"), which are the most effective forms of birth control. In that same year, PPLM performed more than 65,000 STI tests, which represents a substantial portion of the STI tests performed in Massachusetts.

28. PPLM also provides its patients critical health education, especially about breast and cervical cancer screening, diagnosis, follow-up, and referral to medical specialists in the community. PPLM provides health education services to the general public as well, offering age-appropriate and medically accurate sexual education programs in public schools and in the broader communities in which PPLM operates.

29. Massachusetts is in great need of the services that PPLM provides. Two of PPLM's health centers are in communities classified by the federal government as Medically Underserved Areas ("MUAs"), and three of PPLM's health centers are in communities classified by the federal government as Medical Care Health Professional Shortage Areas ("HPSAs").[3] A substantial part of PPLM's education services are provided to individuals in communities experiencing significant health disparities. PPLM's health centers offer early morning, limited evening, and weekend hours along with walk-in appointments and same-day contraception, including highly effective LARCs.

[3] HPSAs are designated by the Health Resources and Services Administration ("HRSA"), an agency of the U.S. Department of Health and Human Services ("HHS"), as having shortages of primary medical care, dental or mental health providers. MUAs have a shortage of primary care health services for residents within a geographic area.

30. A core part of PPLM's mission is to provide sexual and reproductive health care, including abortion, to individuals with low incomes. In 2024, PPLM provided services to approximately 10,822 patients—nearly 35% of PPLM's patient base—who were enrolled in Medicaid. In 2024 alone, PPLM provided through Medicaid more than 5,237 units of contraception (including 1,255 LARCs), 242 cervical screenings, 257 breast cancer exams, and 21,463 STI tests (yielding over 500 positive results that would have otherwise gone undiagnosed). In 2024, PPLM received a significant portion of its patient revenue (approximately 39%) from Medicaid reimbursements.

31. PPLM clinics in recent years have served a significant portion of patients who seek reproductive health care from publicly funded clinics in Massachusetts, including 54% of Massachusetts patients that received family planning services through Medicaid.

32. In 2024, PPLM referred more than 2,100 patients to other providers for a variety of types of care, including diagnosis and management of chronic diseases including cancer, diabetes, cardiovascular disease, mental health, obstetric and breast specialist care, human immunodeficiency virus ("HIV") care, infertility, and dermatology. Many of those patients initially came to PPLM health care centers for other needs in addition to family planning services, and would likely not have received treatment for their illnesses if not for the PPLM staff, who were able to accurately diagnose their conditions and connect them with appropriate medical professionals. PPLM also engages in advocacy activities to protect and expand access to sexual and reproductive health care, including abortion, and education.

33. PPLM brings this action on behalf of itself and its patients.

34. **Plaintiff Planned Parenthood Association of Utah ("PPAU")** is a 501(c)(3) not-for-profit corporation organized under the laws of Utah. Its principal office is in Salt Lake City, Utah. PPAU operates six health centers across the State of Utah, located in Ogden, Orem, Salt Lake City (which has two health centers), South Jordan, and West Valley City. PPAU also offers some types of care through telehealth.

35. PPAU is a separately incorporated, independently operated organization and a Planned Parenthood Member.

36. PPAU provides a full range of sexual and reproductive health services, including well-person preventative care visits; breast exams; pap tests; STI testing; a wide range of U.S. FDA-approved contraception methods, including highly effective, long-acting reversible contraceptives; pregnancy testing; risk assessments for pregnant patients to screen for high-risk issues; referral services for pregnant patients; urinary tract infection treatment; cervical cancer and testicular cancer screening; fertility awareness services; vasectomies; and abortions. All of PPAU's health centers generally offer same-day appointments and walk-in availability, and two of PPAU's health centers generally offer weekend, early morning, and evening hours.

37. In 2024, PPAU provided health care to nearly 30,000 patients through more than 44,000 total visits to its health centers, including 19,341 birth control pills, 2,278 implantations of intrauterine devices, 12,303 pregnancy tests, 89 vasectomies, 1,592 pap tests, and 2,676 abortions.

38. PPAU also provides comprehensive education about sexual and reproductive health. Through its research-based education programs, PPAU works to provide all Utahns with the accurate, reliable information they need to make responsible decisions and stay healthy. In 2024, PPAU's educators reached 5,106 individuals throughout Salt Lake County, Utah County,

and Summit County. Four of PPAU's health centers are in communities classified by the federal government as HPSAs.

39. Like all other eligible Planned Parenthood Members throughout the country, PPAU is a Medicaid-enrolled provider. PPAU provides health care to patients who rely on Medicaid for health insurance and seeks reimbursement from Medicaid funds for the provision of eligible health care services.

40. PPAU does not limit the number of Medicaid patients it serves. Of the nearly 30,000 patients PPAU served in 2024, 2,096 were Medicaid-enrolled patients. In federal fiscal year 2023, PPAU received $706,251 in Medicaid reimbursements.

41. PPAU brings this action on behalf of itself and its patients.

42. **Defendant Robert F. Kennedy, Jr.** is the Secretary of Health and Human Services and is that agency's highest ranking official. He is charged with overseeing the federal agency responsible for the Medicaid program and the Defund Provision. He is sued in his official capacity.

43. **Defendant U.S. Department of Health and Human Services** (including all subagencies over which HHS exercises legal control) is an executive department of the United States.

44. **Defendant Mehmet Oz** is the Administrator for the Centers for Medicare & Medicaid Services. He is charged with administering the Medicaid program and the Defund Provision. *See* Section 71113(c) (appropriating funds "to the Administrator of the Centers for Medicare & Medicaid Services" "[f]or the purposes of carrying out this section"). He is sued in his official capacity.

45. **Defendant Centers for Medicare & Medicaid Services** is an agency within the U.S. Department of Health and Human Services.

THE RELATIONSHIP BETWEEN PPFA AND ITS MEMBERS

46. PPFA is a mission-driven membership organization whose membership includes the 47 accredited Members. Each Member is a separately incorporated 501(c)(3) organization with its own CEO, board of directors, staff, books, and operations.

47. Under PPFA's governance structure, the PPFA Membership elects PPFA's Board of Directors; approves changes to PPFA's bylaws and membership standards; approves PPFA's long-range goals; and determines the amount each Member pays in annual dues.

48. PPFA supports its Members in a variety of ways. For example, PPFA administers the accreditation standards for the Membership, promulgates certain shared medical standards and guidelines, and provides leadership around certain shared policy and program initiatives. PPFA also provides practical support such as technical assistance and consultant services, programmatic grants, and fundraising support. While Members receive some grant and other funding through PPFA, overall, the vast majority of each Member's revenue comes from sources other than PPFA.

49. In addition to maintaining separate corporate structures, PPFA and its Members maintain separate finances and day-to-day operations. For example, PPFA and each member maintain separate general ledgers and file taxes separately from one another. Each has separate payrolls and employee rosters, and PPFA has no role in its Members' respective staffing or employment decisions.

50. PPFA membership is important to Members' ability to fulfill their missions. PPFA licenses the use of the Planned Parenthood name and well-known trademark to each Member—a

name that sends a powerful message to the community that the Member stands for certain values and provides high-quality health care and educational services in furtherance of the shared Planned Parenthood mission. Planned Parenthood Members are viewed in communities throughout the country as providing nonjudgmental, welcoming, and compassionate care to patients seeking health care, including sexual and reproductive health care.

51. Planned Parenthood Members' structural independence means that no Member has control over the operations or decision-making processes of another. The actions or policies of one Planned Parenthood Member do not legally or operationally bind the others.

52. PPFA does not exercise control over any Member, or vice versa.

PLANNED PARENTHOOD MEMBERS' ROLE IN PROVIDING CRITICAL SEXUAL AND REPRODUCTIVE HEALTH CARE SERVICES IN THE UNITED STATES

53. Collectively, the 47 Planned Parenthood Members provide care to more than 2 million patients each year. An estimated one in three women and one in ten men have received care from a Planned Parenthood Member. This number is even higher among individuals with Medicaid, 43% of whom have received services from a Member health center.

54. All Planned Parenthood Members offer a wide range of sexual and reproductive health care, including contraception (including LARCs), contraceptive counseling, preventive care visits, physical exams, clinical breast exams, screening for cervical and breast cancer, STI screening, testing and treatment, pregnancy testing and counseling, pre-exposure prophylaxis for HIV prevention, the HPV vaccine, and health education services. Most Planned Parenthood Members offer gender-affirming hormone therapy. Planned Parenthood Members also provide abortion in every jurisdiction where it is lawful to do so.

55. For fiscal year 2023 to 2024, Planned Parenthood Members provided approximately 9,400,000 services to 2,080,000 patients who visited Planned Parenthood Member health centers. Planned Parenthood Members' health centers provided more than 350,000 pap tests and breast exams, 5,100,000 STI tests and treatments, and 400,000 abortions. Planned Parenthood Member health centers also provided 2,200,000 birth control services.

56. Planned Parenthood Members' expertise and specialization in family planning, evidence-based practices, and technology often make their health centers the top choice for individuals seeking high-quality sexual and reproductive health care.

57. Planned Parenthood Members are providers of compassionate, non-judgmental, and culturally sensitive care related to reproductive health and sexuality. Topics of this sort can be highly sensitive for patients, some of whom may find it difficult to discuss issues of sexuality or to seek treatment for reproductive- or sex-related conditions, such as STIs. Indeed, because of their concerns about privacy and being judged, many individuals use Planned Parenthood Members as their provider for sexual and reproductive health care services even when they use other providers for their other health care needs.

58. Patients often find Planned Parenthood Member health centers to be much more accessible than alternative providers—to the extent alternatives are even available in their communities, which is often not the case. Most Planned Parenthood Member health centers offer extended (early morning, evening, or weekend) hours. The availability of extended hours and same-day appointments is particularly important for many patients with low incomes who often work long or extended hours and have childcare responsibilities, and do not have the flexibility to attend appointments during the traditional 9-to-5 workday.

59. Planned Parenthood Member health centers are significantly more likely than other publicly funded family-planning clinics to use a variety of protocols that enhance contraceptive method initiation and continuation. For example, a recent survey conducted by the Guttmacher Institute reported that 99% of Planned Parenthood Member health centers provided at least ten reversible contraceptive methods on-site, compared with 63 to 90% of other provider types surveyed. Planned Parenthood Member health centers were also more likely than all other types of clinics to provide a LARC method of contraception.

60. PPFA Members also play a critical role in responding to public health crises. For example, Members expanded their use of telehealth, including for medication abortion, in response to the COVID-19 pandemic.

61. And after the Supreme Court's ruling in *Dobbs v. Jackson Women's Health Organization* led to the implementation of abortion bans in many states and thus an abortion access crisis, Planned Parenthood Members opened health centers in states where abortion remained legal close to the borders of states with abortion bans and expanded staffing and hours in access states.

62. In connection with its mission to ensure access to sexual and reproductive health care, including abortion care, PPFA is committed to supporting the advancement of research and technology in sexual and reproductive health. For example, PPFA and its Members have led and participated in research concerning contraceptive methods as well as human papillomavirus ("HPV") vaccine completion, sharing this research in journal articles and presentations at medical and public health conferences.

PLANNED PARENTHOOD MEMBERS' SERVICE TO UNDERSERVED AREAS AND COMMUNITIES

63. PPFA and its Members share a critical mission to ensure access to sexual and reproductive and complementary health care, including abortion, to individuals and communities that historically have faced barriers to access. Many of PPFA and its Members' educational outreach efforts make a special effort to reach individuals who live in underserved areas and/or have low incomes.

64. In many communities throughout the country, a Planned Parenthood Member health center is the only place that a patient can turn to for high-quality, compassionate, and affordable sexual and reproductive health care. 74% of Planned Parenthood Member health centers are located in rural areas, HPSAs, or MUAs.

65. Planned Parenthood Member health centers also play an increasingly critical role in serving communities of color and in many cases are the only health centers located in such communities. In the 2023-2024 reporting period, approximately 34% of Planned Parenthood Members' patients were white, 27% were Latino/a, 17% were Black, 12% did not disclose their race or their race was unknown, 4% were Asian American/Pacific Islander, 0.5% were American Indian/Alaskan Native, 4% were another race, and 2% were multiracial. As this data shows, Planned Parenthood Members serve a disproportionate number of patients of color as compared to the U.S. population.

66. Planned Parenthood's role in serving communities of color is especially important given the barriers to care that such communities often face. In particular, Planned Parenthood Member health centers are a critical source of care for Black and Latina women, who disproportionately face barriers to preventive health screening. Nearly half of Black women in the

United States have been to a Planned Parenthood Member health center. And in 2023, a greater percentage of Latina women (approximately 15%) were uninsured compared to women of any other racial or ethnic group, and more than 16% lived in poverty. Along those same lines, 6.9% of Black women were uninsured, and 16.8% lived in poverty during the same span.

67. Many Planned Parenthood Member health centers have bilingual or multilingual staff; many also have access to interpretation and translation services. PPFA and its Members often provide educational materials in English, Spanish, and other languages spoken by the patients in the communities they serve.

PLANNED PARENTHOOD MEMBERS' SERVICE TO MEDICAID PATIENTS

68. Since 1965, Medicaid has provided health coverage for eligible families and individuals with low incomes. Medicaid is a joint federal-state program under which the federal government provides financial assistance to participating States to help them furnish care to persons in need. No State is required to participate, but if it does, it must comply with a range of federal statutes and regulations and must administer the program in accordance with federal law. Currently, all 50 States and the District of Columbia participate in Medicaid.

69. Eligible individuals who receive Medicaid may choose to obtain care at participating health care providers. Health care providers are not required to accept Medicaid, and many non-Planned Parenthood Member providers do not accept Medicaid patients at all, or effectively limit the number of Medicaid patients whom they will serve. This is primarily because Medicaid reimbursement rates have historically been well below those of Medicare or private insurance rates.

70. For participating health care providers, Medicaid typically works by reimbursement. Specifically, the health care provider cares for the Medicaid-enrolled patient and submits to the Medicaid program a claim for a reimbursement for the specific covered health care services provided, and the Medicaid program then reimburses the provider. The majority of the funding for Medicaid is provided by the federal government, but the program is administered at the state level, with the amount of state funding and the exact way in which the program is administered varying from state to state. States have the option to require cost-sharing (including deductibles and copays) from beneficiaries, but those cost-sharing requirements are generally nominal and cannot be imposed for family planning services.

71. Each year, Planned Parenthood Members collectively serve approximately two million people, more than half of whom receive care through Medicaid. Planned Parenthood Members provide their Medicaid patients with comprehensive sexual and reproductive health care services, such as STI/HIV screenings and treatments, pelvic exams, and contraception, including LARCs.

72. As a result of their commitment to serving Medicaid patients whom many other providers would not serve, Planned Parenthood Members received more than one third of their total revenue from Medicaid reimbursements in federal fiscal year 2023. Some Members received the vast majority (over three quarters) of their total revenue from Medicaid reimbursements that year. By participating in the Medicaid program, Planned Parenthood Members can serve low-income patients at no cost to those patients and are thus able to ensure access to sexual and reproductive health care for communities in need.

PLANNED PARENTHOOD'S ADVOCACY FOR, AND PROVISION OF, ABORTION SERVICES

73. Consistent with—and indeed critical to—their core missions of ensuring access to comprehensive sexual and reproductive health care for all, PPFA and its Members advocate for access to safe and legal abortion for individuals who wish to terminate a pregnancy, and Members in states where it is legal provide abortions. Abortion services represent a small fraction (4%) of the total services offered by Members collectively and are offered only at some health centers. The vast majority of the services provided by Members are preventive sexual and reproductive health care services, such as STI testing and treatment and contraceptive services.

74. When a patient comes to a Planned Parenthood Member health center because they may be interested in seeking an abortion, consistent with sound medical practice, Planned Parenthood Members provide educational information to the patient about all the options available to them, including the option of a safe and legal abortion.

75. In many communities, a Planned Parenthood Member is the only abortion provider, or is the only place where an individual can obtain an abortion without traveling long distances. The difficulty of obtaining an abortion is made worse by the fact that nineteen states have an abortion ban in effect. As a result, health centers across these states have shuttered, making it more difficult for patients to access a variety of other health care, including preventative health services. In 2024, 155,000 people traveled out of their home state for abortion care.

76. For decades, federal law has prohibited the use of federal funds for abortions except in narrow circumstances (*i.e.*, where the pregnant person's life would be endangered by carrying to term, or where the pregnancy is the result of rape or incest). No federal funds, including

Medicaid funds, are used to reimburse Planned Parenthood Members for abortion services except under the extremely limited circumstances authorized by federal law.

LEGISLATIVE HISTORY REAFFIRMS THAT THE DEFUND PROVISION SPECIFICALLY TARGETS PLANNED PARENTHOOD

77. For over a decade, President Trump and his political allies in Washington have tried to coerce Planned Parenthood Members into abandoning the provision of abortion care, and to penalize Members and PPFA for advocating for abortion access.

78. While these efforts are commonly referred to as efforts to "defund" Planned Parenthood, it bears emphasis that there is no line item in the federal budget for Planned Parenthood. Rather, Planned Parenthood Members, like any other health care providers in the Medicaid program, provide services to their patients and then typically submit a claim for reimbursements to Medicaid to cover those services. What the Defund Provision does is bar certain Planned Parenthood Members from receiving federal Medicaid funds and thus, in effect, from providing health care through the Medicaid program.

79. The Trump Administration and its political allies have tried to pass this bill before. In 2017, Congress considered—and narrowly rejected—a bill that included language nearly identical to the Defund Provision. It was clear then that that language was intended to target Planned Parenthood, and it remains clear now.

80. In fact, the failed attempt to pass the same law dates back a decade, to August 2015, when then-candidate Trump was asked whether he would support shutting down the federal government to "get rid of Planned Parenthood money." President Trump replied, "I would … I think you have to in this case."

81. One month later, Trump stated emphatically that he was "not supporting Planned Parenthood." He added that he would be "totally opposed to funding" Planned Parenthood as long as they provided abortions.

82. In February 2016, Trump stated in a debate that he would end federal funding for Planned Parenthood, asserting that he would "defund it because [he's] pro-life."

83. In September 2016, Trump wrote a letter to "Pro-Life Leader[s]," indicating that he was "committed to … [d]efunding Planned Parenthood as long as they continue to perform abortions." Fast forward four years and Trump again wrote to "Pro-Life Leaders and Activists," promising to "[f]ully defund the big abortion industry such as Planned Parenthood of our tax dollars."

84. In May 2017, President Trump became the first sitting president to single out Planned Parenthood and call for its "defunding."

85. During President Trump's first term in office, there were also frequent congressional efforts to "defund" Planned Parenthood. The Republican-led House sought to repeal a rule barring state and local governments from withholding Title X—a federal grant program that covers the provision of family planning services—funds from family planning providers that, like Planned Parenthood Member health centers, offered full sexual and reproductive health care services, including abortions. H.R.J. Res. 43, 115th Cong. (2017); Compliance with Title X Requirements by Project Recipients in Selecting Subrecipients, 81 Fed. Reg. 91852 (Dec. 19, 2016) (codified at 42 C.F.R. pt. 59). That rule was a response to more than a dozen attempts by states to "defund" Planned Parenthood by way of excluding its Members from receiving public funds.

86. Both the House and Senate tried to "defund" Planned Parenthood as part of their efforts to overhaul the Affordable Care Act ("ACA"). 42 U.S.C. § 18001 *et seq.* The "American Health Care Act of 2017" and its Senate analog, the "Better Care Reconciliation Act of 2017," proposed restricting access to Medicaid reimbursements from family planning providers that offer abortion services, using substantially the same language as the Defund Provision. American Health Care Act of 2017, H.R. 1628, 115th Cong. (2017); S. Amend. 267, 115th Cong. (2017). Although H.R. 1628 did not expressly mention Planned Parenthood then, just as the Defund Provision does not now, the bill's supporters acknowledged that the legislation was designed to target Planned Parenthood. For example, during the March 24, 2017, floor debate on H.R. 1628, Representative Matt Gaetz "implore[d] [his] conservative colleagues to vote for this bill" because it would result in "$1.15 trillion in spending cuts" and would "defund[] Planned Parenthood." 163 Cong. Rec. H2373, H2409 (daily ed. Mar. 24, 2017) (statement of Rep. Gaetz). He then asked, "How long have we been fighting to defund Planned Parenthood?" underscoring that "defunding" Planned Parenthood was one of the bill's key objectives. *Id.* Later that day, Representative Kevin Brady likewise stated, "I am proud to defund Planned Parenthood once and for all." *Id.* at H2433. H.R. 1628 passed the House but stalled in the Senate.

87. As drafted, H.R. 1628's definition of "prohibited entity" largely tracked that in the Defund Provision. H.R. 1628 applied only to family planning providers that provide abortions and received more than $350 million in Medicaid funds in fiscal year 2014. That number was no accident, but rather yet more proof of the intended target of the bill: Planned Parenthood Members collectively received over $350 million in Medicaid funds that year. No other organization or association came close.

88. Because the Senate parliamentarian determined that "prohibit[ing]" only "Planned Parenthood from receiving Medicaid funds for one year" violated a Senate rule (the Byrd Rule),[4] the bill was then revised so as to purportedly bring one other unidentified entity within its scope. In the Senate version of the bill, the threshold for qualification was reduced from $350 million to $1 million for the sole purpose of evading the restrictions of the reconciliation process. While the Parliamentarian inexplicably allowed the bill to move forward with that change, there is no question that the true purpose of that bill was to express disapproval of and to punish Planned Parenthood.

89. Although these congressional efforts to ban Planned Parenthood from receiving federal funding ultimately failed in 2017, President Trump then sought to permit states to accomplish what he and Congress could not. In 2018, for example, President Trump's HHS Secretary revoked guidance that had prohibited states from excluding providers from eligibility for Medicaid reimbursement because they also provided abortions. Letter from Brian Neale, Director, Ctr. for Medicare & CHIP Servs., and Alec Alexander, Director, Ctr. for Program Integrity, to State Medicaid Dirs. (Jan. 19, 2018).

90. During the Biden Administration, congressional efforts to "defund" Planned Parenthood continued. House members introduced bills that openly sought to "defund" Planned Parenthood unless it certified that it would not provide abortions. For example, H.R. 128, 118th Cong. (2023), the "Defund Planned Parenthood Act of 2023," introduced by Representative Lauren Boebert (Colorado), and H.R. 371, 118th Cong. (2023), "Defund Planned Parenthood Act

[4] S. Comm. on the Budget, 115th Cong., Background on the Byrd Rule Decisions from the Senate Budget Committee Minority Staff (July 21, 2017), https://www.budget.senate.gov/imo/media/doc/Background%20on%20Byrd%20Rule%20decisions_7.21[1].pdf.

of 2023," proposed by Representative Michelle Fischbach (Minnesota), sought to restrict any federal funding for Planned Parenthood, or any of its affiliates or clinics, for one year unless it certified that its affiliates and clinics would not perform, and would not provide funds to entities that perform, abortions during that year. In a press release announcing H.R. 128, Representative Boebert stated, "[t]he nation's largest abortion provider has no business receiving taxpayer dollars."[5] Similarly, Representative Fischbach stated of her bill, "[o]rganizations like Planned Parenthood receive millions of hard-earned taxpayer dollars every year to provide abortions on demand."[6] Other bills, like H.R. 6176, 118th Cong. (2023), introduced by Representative Robert B. Aderholt (Alabama), simply aimed "to prohibit Federal funding of Planned Parenthood Federation of America." Similar bills were introduced in the Senate.[7]

91. And saying the quiet part out loud, entities politically opposed to abortion released ads and other materials seeking to defund Planned Parenthood's Members in part because of the work of its related electoral organizations. For example, Susan B. Anthony Pro-Life America announced the launch of a six-figure TV and digital ad campaign that followed sensational accusations about Planned Parenthood's abortion services with the conclusion, "all while they spend hundreds of millions supporting Democrats. Stop forced taxpayer funding of the Big

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[5] Press Release, Rep. Lauren Boebert Introduces the Defund Planned Parenthood Act (Jan. 20, 2023), https://boebert.house.gov/media/press-releases/rep-lauren-boebert-introduces-defund-planned-parenthood-act.

[6] Press Release, Rep. Fischbach Introduces the Defund Planned Parenthood Act and Protecting Life and Taxpayers Act (Jan. 19, 2023), https://fischbach.house.gov/press-releases?ID=67C83E37-B8FF-4E7C-AC0B-4EB21AAE68F9.

[7] *See, e.g.*, Defund Planned Parenthood Act, S. 203, 119th Cong. (2025) (introduced by Sen. Paul (Kentucky)); H.R. 271, 119th Cong. (2025) (introduced by Rep. Fischbach (Minnesota)); Protecting Funding for Women's Health Care Act, S. 177, 119th Cong. (2025) (introduced by Sen. Ernst (Iowa)); H.R. 599, 119th Cong. (2025) (introduced by Rep. Aderholt (Alabama)).

Abortion industry. Defund Planned Parenthood."[8] Students for Life Actions "National Month of Mobilization to DEFUND Planned Parenthood & Big Abortion" included, as its "Week Five Theme" a suggestion that its members contact their Senators to tell them that "Planned Parenthood is funding their political enemies," and specifically that"[a]head of last November's elections, they spent $69.5 million bolstering pro-abortion President Joe Biden & leading congressional Democrats."[9]

92. The second Trump Administration picked up its efforts to "defund" Planned Parenthood right where the first left off. Project 2025, a proposed "governing agenda" for the Trump administration organized by the Heritage Foundation, encouraged Congress to pass the "Protecting Life and Taxpayers Act," which "would accomplish the goal of defunding abortion providers such as Planned Parenthood." Although President Trump distanced himself from Project 2025 during his 2024 campaign, its proposed policies track President Trump's actions targeting Planned Parenthood during his first term in office, are in line with his stated intention to "defund" Planned Parenthood because it provides abortion services, and have now been implemented through the Defund Provision.

93. These efforts to "defund" Planned Parenthood culminate now with the enactment of the Defund Provision, which comes as no surprise. Speaker Johnson confirmed in 2024, before the current congressional term began, that "defunding" Planned Parenthood continued to be at the

[8] Press Release, Six-Figure Ad Campaign Exposes How Big Abortion's Substandard 'Care' Harms Women & Girls (July 1, 2025), https://sbaprolife.org/newsroom/press-releases/six-figure-ad-campaign-exposes-how-big-abortions-substandard-care-harms-women-girls.

[9] Join Students for Life's National Month of Mobilization to DEFUND Planned Parenthood & Big Abortion,' Students for LifeAction, https://www.studentsforlifeaction.org/defund/.

top of the Republican agenda in the House. In an interview with Fox News at the end of 2024, Speaker Johnson confirmed while discussing budget cuts, that he was planning to "axe" funding for Planned Parenthood.[10] On April 29, 2025, during a keynote address at a fundraising event, Speaker Johnson reiterated, "In the weeks ahead, the House is going to be working on the one big, beautiful bill . . . . And we're absolutely making it clear to everybody that this bill is going to redirect funds away from Big Abortion."[11] "Big Abortion" has long been used by anti-abortion groups as a derogatory synonym for Planned Parenthood.

94. Other Members of Congress have made similar statements. For example, Representative Christopher Smith called for the "defunding of Planned Parenthood" to penalize it for performing abortions. 171 Cong. Rec. E255 (2025) (statement of Rep. Smith). And despite acknowledging that defunding Planned Parenthood "doesn't save money," Representative Andy Harris called on Congress to include reconciliation language to defund Planned Parenthood because "[w]e shouldn't be paying for institutions whose primary purpose is to do abortions."[12]

95. Congress has now chosen to defund Planned Parenthood in the same way that failed in 2017. The Defund Provision initially started with the $1 million eligibility threshold where the 2017 bill left off, but was again scaled down—this time to $800,000—again to overcome the Byrd Rule. To the best of Plaintiffs' knowledge, this lower eligibility threshold may mean that a small

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[10] Speaker Mike Johnson, *Speaker Johnson Joins The Story with Martha MacCallum*, YOUTUBE (Dec. 4, 2024), https://www.youtube.com/watch?v=VOM5wRs1WFc.

[11] SBA Pro-Life America, *Speaker Mike Johnson at the SBA Pro-Life America Gala 2025*, YOUTUBE (Apr. 29, 2025), https://youtu.be/vZFDkKzIfq4?si=TZrNGsZRJ9Oigsct&t=794.

[12] Alice Ollstein, *Knives Are Out for Planned Parenthood. In All 3 Branches of Government*, POLITICO (Feb. 13, 2025), https://www.politico.com/newsletters/politico-nightly/2025/02/13/knives-are-out-for-planned-parenthood-in-all-3-branches-of-government-00204234.

number of additional entities have been swept into the statute's coverage as collateral damage. But the intent remains the same: to defund Planned Parenthood.

THE SWEEPING EFFECTS OF THE DEFUND PROVISION

Section 71113: Text and Purpose

96. Section 71113, enacted through the reconciliation process, is the latest attempt to single out and penalize Planned Parenthood.

97. The Defund Provision bars federal Medicaid funds from being "used to make payments" to a "prohibited entity" "for items and services furnished during the 1-year period beginning on the date of the enactment of this Act."

98. The Defund Provision applies only to entities that meet the statutory definition of a "prohibited entity" "as of the first day of the first quarter beginning after the date of enactment of this Act." But it prohibits federal funds from being disbursed "for items and services furnished during the 1-year period beginning *on the date of the enactment of this Act*." Accordingly, even if one cannot know if an entity will qualify as a "prohibited entity" until next quarter, such a "prohibited entity" would be prohibited from receiving Medicaid reimbursements for any services provided as of July 4, 2025.

99. By design, the Defund Provision defines "prohibited entity" in such a way as to specifically target Planned Parenthood. In particular, the statute defines "prohibited entity" to mean an entity, "including its affiliates, subsidiaries, successors, and clinics," that meets four criteria:

> (1) it "provides for abortions," other than abortions in the case of rape or incest or where the woman's life is in danger;
>
> (2) it "is an organization described in section 501(c)(3) of the Internal Revenue Code … and exempt from tax under section 501(a) of such Code";
>
> (3) it "is an essential community provider described in" 45 C.F.R. § 156.235 "that is primarily engaged in family planning services, reproductive health, and related medical care"; and
>
> (4) "for which the total amount of Federal and State expenditures under the Medicaid program … in fiscal year 2023 made directly, or by a covered organization, to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded $800,000."

100. PPFA itself does not provide health care, including abortion care, and has never received Medicaid funds. Nor is it "an essential community provider." PPFA is therefore not a "prohibited entity" under the statute.

101. But the statute's criteria are specifically drafted to target Planned Parenthood Members. When taken together, to the best of Plaintiffs' knowledge, all but a small number of the entities that satisfy these criteria—that provide abortions, are 501(c)(3) organizations, are essential community providers, and received more than $800,000 in Medicaid funds in fiscal year 2023—are Planned Parenthood Members. And there is no indication that Members of Congress were even aware that any other entity could qualify under this statute that was clearly designed to target Planned Parenthood alone.

102. Underscoring that Congress targeted Planned Parenthood—and Planned Parenthood alone—is the fact that nearly all other *abortion* providers fall *outside* the scope of a "prohibited entity" under the statute by design. That includes providers that are not non-profit

organizations, that are not essential community providers that primarily provide family planning and reproductive health services, and/or that did not receive more than $800,000 in Medicaid funds in fiscal year 2023. All those providers remain eligible to receive Medicaid funds, while Planned Parenthood Members are prohibited from doing so.

103. Some Planned Parenthood Members, including PPLM, independently satisfy the requirements of the Defund Provision, and therefore qualify as "prohibited entit[ies]" under the statute.

104. Other Planned Parenthood Members, including Plaintiff PPAU, fall outside the scope of this definition because they do not provide abortion services or did not receive over $800,000 in Medicaid funds during fiscal year 2023.

105. These ten Members (the "Non-Qualifying Members") are also not "affiliates, subsidiaries, successors, or clinics" of any prohibited entity. Each Planned Parenthood Member is a separately incorporated and independently governed non-profit organization, with its own finances, board of directors, and operational structure. As such, one Planned Parenthood Member does not exercise control over any other Planned Parenthood Member such that they could be considered affiliates of one another under the statute. Nor are Planned Parenthood Members controlled by PPFA.

106. But these Non-Qualifying Members can take no comfort in the plain text of the statute. Given the decade-plus focus on "defunding" set out above, there can be no question that they face a serious risk that the Defendants will willfully misinterpret the statute to disqualify them from receiving federal Medicaid funding, based solely on their association with PPFA and other Planned Parenthood Members.

The Devastating and Irreparable Impact of the Defund Provision on Plaintiffs and the Patients and Communities Members Serve

107. If not enjoined, the Defund Provision will have devastating effects on PPFA, its Members, and the patients and communities that Members serve.

108. The Defund Provision will jeopardize care for the more than 1,000,000 Planned Parenthood Member patients who rely on Medicaid—approximately 50% of Planned Parenthood Member patients. As a direct result of the law, patients are no longer able to use Medicaid to receive services at Planned Parenthood Member health centers. Many will not be able to find alternative providers—and thus will lose access to care altogether. Even those who may be able to obtain care from an alternative provider will face delays and disruptions in care, which can be particularly devastating to their health.

109. The Defund Provision will irreparably harm Plaintiff PPLM and the patients it serves. Because PPLM currently meets the requirements to be a "prohibited entity" under the Defund Provision, and that status will not change between now and the "first day of the first quarter beginning after the date of enactment of this Act," PPLM has been forced to stop seeking Medicaid reimbursement upon the Defund Provision's enactment. *See* Section 71113 (barring federal Medicaid funds from being "used to make payments" to a "prohibited entity" "for items and services furnished during the 1-year period beginning on the date of the enactment of this Act").

110. If the Defund Provision is not enjoined, Plaintiff PPLM will be forced to cease providing services to its Medicaid patients. PPLM has nearly 150 scheduled appointments for Medicaid patients across its health centers on July 7 and July 8 alone, and has been reaching out to inform these patients they cannot use their Medicaid coverage for services at PPLM. PPLM is discussing options with patients to try to ensure their access to care, but many of those patients

will likely be unable to find another provider or will face such lengthy wait times that they will be forced to forgo services. Early estimates indicate that the Defund Provision will cause PPLM to lose approximately 35-40% of its annual health care revenue. As a result, PPLM will be forced to make substantial reductions to services, programs, and staffing, potentially up to 20-25%, and ultimately may have no choice but to close some of its health centers altogether. This will deny care not only to its Medicaid patients, but *all* of its patients at those health centers.

111. The Defund Provision will also irreparably harm Plaintiff PPAU and the patients it serves. Because PPAU's health centers cannot afford to provide health care services free of charge, if the Defund Provision is not prevented from going into effect, patients will no longer be able to receive health care services through the Medicaid program at PPAU's health centers. PPAU has already had to turn away Medicaid patients who had appointments in its health centers on Saturday, July 5. And many of PPAU's Medicaid-enrolled patients may be unable to find another provider of affordable, high-quality sexual and reproductive health care in their area, much less one that sees Medicaid patients.

112. In addition to the harms to PPAU's patients, PPAU will also be immediately and irreparably harmed by the Defund Provision. In federal fiscal year 2023, PPAU received $706,251 in Medicaid reimbursements. Even though this means that PPAU does not independently qualify as a "prohibited entity" under the Defund Provision, due to the threat that the government could determine PPAU is a "prohibited entity" based on its association with other Planned Parenthood Members, PPAU has had no choice but to stop seeking Medicaid reimbursement.

113. Losing this revenue will force PPAU to lay off full-time staff, limit the health care services it provides, and potentially close health centers as a result. When the federal government

recently withheld $2.8 million in Title X funds from PPAU—approximately 20% of its overall revenue—PPAU was forced to lay off eighteen full-time staff members (approximately 20% of PPAU's staff) and close two health centers (approximately 20% of its health centers). PPAU will likely similarly have to make proportionate cuts to its health centers and staff if it cannot seek Medicaid reimbursements. Being unable to serve Medicaid patients also makes it more difficult for PPAU to accomplish its mission of ensuring access for Utahns to sexual and reproductive health care.

114. Other Planned Parenthood Members and their patients will also suffer. Where eligible, Planned Parenthood Members provide care to patients enrolled in Medicaid, and care for all of their Medicaid patients will be jeopardized for the same reasons. Most of those patients face serious barriers to health care, and many will be unable to find alternative providers.

115. For example, patients in California face especially devastating impacts. There are seven Planned Parenthood Members located in California,[13] operating 114 health centers throughout the State. Each of the seven California Planned Parenthood Members independently meets the requirements of being a "prohibited entity" under the Defund Provision.

116. The California Members collectively provide care to roughly 700,000 patients, across 1.3 million patient visits, each year. The California Planned Parenthood Members offer a range of sexual and reproductive health care services, including the provision of birth control, including emergency contraception; testing and treatment of sexually transmitted infections;

[13] The seven members are: Planned Parenthood Northern California ("PPNorCal"); Planned Parenthood Mar Monte ("PPMM"); Planned Parenthood California Central Coast ("PPCCC"); Planned Parenthood Los Angeles ("PPLA"); Planned Parenthood Pasadena and San Gabriel Valley ("PPSGV"); Planned Parenthood Orange and San Bernardino Counties ("PPOSBC"); and Planned Parenthood Pacific Southwest ("PPPSW").

pregnancy testing and services; breast and cervical cancer screenings; gender-affirming care, and abortion. In addition, all seven California Planned Parenthood Members offer education and counseling on sexual and reproductive health, reaching over 100,000 Californians every year.

117. Over 80% of Planned Parenthood Member patients in California rely on California's Medicaid program ("Medi-Cal") and its related programs for their health care coverage. Current budget estimates show that federal funds cover around 60% of the total Medi-Cal program expenditures.

118. As a result of the Defund Provision, Medicaid payments will be prohibited for the vast majority of services that the California Members provide to the more than 25,000 patients their health centers serve every week. Medicaid payments constitute approximately two thirds of the California Members' collective revenue.

119. Without immediate relief, the seven California Planned Parenthood Members will be forced to close health centers and reduce hours, staff, and services, and Californians—whether enrolled in Medi-Cal or not—will lose important points of access for their sexual and reproductive health care needs.

120. Closures of California Planned Parenthood Members' health centers would mean that there will be fewer family planning providers in the Medi-Cal program, leading to longer wait times and more barriers to care as Californians may need to travel significant distances to receive in-person care.

121. Such closures will likely leave many patients with no other options from which to receive the health care they need. In California, Planned Parenthood Member health centers see approximately half of all patients in California served at a publicly funded clinic. Federally

qualified health centers are already struggling to meet a rapidly increasing demand for services and will be unable to absorb Planned Parenthood Members' patients. The California Primary Care Association ("CPCA"), which represents the community clinics in California, has stated that these clinics do not have the capacity to take on Planned Parenthood Members' patients.

122. Across the country, Planned Parenthood Members' patients with low incomes, patients in rural areas, patients who are not proficient in English, and patients of color will disproportionately suffer the consequences of the Defund Provision. Those patients and communities already face serious barriers to health care that would only worsen if they cannot use Medicaid to receive services at Planned Parenthood Members' health centers, including because health centers are forced to close and others are forced to limit their hours or curtail their services.

123. Indeed, Planned Parenthood Members provide an extraordinary proportion of the Nation's publicly funded sexual and reproductive health services. Moreover, Planned Parenthood Member health centers focus on sexual and reproductive health services; other publicly funded health centers may offer a broad range of primary and acute medical services, but lack the strong focus on sexual and reproductive health and experience providing that care that Planned Parenthood Members have. Put simply, other publicly funded health centers, already stretched to capacity, will not be able to make up the drastic shortfall in coverage that will result from the Defund Provision. The statute will thus create an immediate health care crisis for hundreds of thousands of patients, if not more.

124. The adverse public health consequences of the gap in services that will result from the Defund Provision will be grave, leading to significant adverse public health outcomes, including, among other things, higher rates of STIs and more unintended pregnancies.

125. If not enjoined, the Defund Provision will frustrate PPFA's and its Members' mission to ensure access to sexual and reproductive health care services to individuals regardless of their ability to pay. PPLM, PPAU, and other Planned Parenthood Members face the immediate prospect of having to turn away patients, curtail services, terminate employees, and close health centers. Even if the Defund Provision is held unconstitutional at the end of this lawsuit, absent a temporary restraining order and preliminary injunctive relief, Planned Parenthood Members would not be able to resume relationships with the patients that they lost, reconstitute the programs and services that were terminated, or recall the employees that were essential to serving those patients. Planned Parenthood Members' patients will also be harmed by the loss of their health care provider of choice, and even if they are able ultimately to find an alternative provider, will suffer from a loss of continuity of care with their established provider.

126. If Member health centers are forced to curtail services or close as a result of the Defund Provision they could not be reopened without extensive additional investment in infrastructure. Thus, even if in future years Members are permitted to obtain federal Medicaid reimbursement, such funds would not be sufficient to provide Planned Parenthood Members the capital needed to renew services and reopen clinics for the patients that they would have lost as a result of the Defund Provision.

127. Planned Parenthood Members have a reputation among the patients and the communities they serve for offering reliable and comprehensive health care. The disruption in services and care offered by PPLM, PPAU, and other Members as a result of the Defund Provision will diminish their reputations as providers of reliable and comprehensive health care. It has taken years for Planned Parenthood Members to build such reputational capital. Indeed, many Planned

Parenthood Members have been in their communities for decades. Once disrupted, such reputational capital cannot be readily rebuilt.

128. These harms to PPLM, PPAU, and other Planned Parenthood Members across the Nation will also harm PPFA. By preventing Planned Parenthood Member health centers from serving Medicaid patients and other vulnerable patients with low incomes across the Nation, the Defund Provision strikes at the heart of PPFA's core mission of ensuring access for all to sexual and reproductive health care, including abortion, regardless of patients' ability to pay. Although PPFA does not directly operate health care centers, it will face substantial reputational, operational, and mission-related injury if the Defund Provision is not enjoined.

129. PPFA, its Members, and their patients have no adequate remedy at law.

CLAIMS FOR RELIEF

COUNT ONE
ARTICLE ONE: BILL OF ATTAINDER

130. Paragraphs 1 through 129 above are incorporated and reasserted as if fully set forth herein.

131. The Constitution instructs Congress that "[n]o Bill of Attainder … shall be passed." U.S. Const. art. I, § 9, cl. 3.

132. The Act constitutes an unconstitutional bill of attainder because the Defund Provision specifies and punishes PPFA and its Members without a judicial trial.

133. While the Defund Provision does not identify Planned Parenthood by name, it defines "prohibited entity" specifically to target Planned Parenthood.

134. The Defund Provision also uses language nearly identical to that proposed, but not enacted, in 2017. The history and context surrounding that version of the bill, which is functionally

the same as the Defund Provision now enacted with respect to who is a "prohibited entity," clearly indicates that it was intended to exclude Planned Parenthood, and Planned Parenthood alone, from the Medicaid program. Events since 2017, as well as the history and context of the Defund Provision itself, also demonstrate that the challenged law was intended to target Planned Parenthood.

135. The Defund Provision specifically punishes Planned Parenthood Members by making them ineligible for Medicaid reimbursement.

136. Accordingly, Plaintiffs are entitled to a declaratory judgment, judgment awarding them preliminary and permanent injunctive relief, attorneys' fees, costs, and any other relief the Court deems just and appropriate.

COUNT TWO
FIFTH AMENDMENT: EQUAL PROTECTION

137. Paragraphs 1 through 129 above are incorporated and reasserted as if fully set forth herein.

138. The equal protection component of the Due Process Clause of the Fifth Amendment requires that "all persons similarly situated should be treated alike." *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985).

139. By its terms, the Defund Provision reaches only "prohibited entit[ies]," which is defined to encompass Planned Parenthood. As the statute's supporters have confirmed in public statements, that definition is designed to single out Planned Parenthood.

140. The Defund Provision purposefully treats Planned Parenthood Members unlike other organizations that provide the same medical care. Others who provide abortion and also

receive Medicaid payments for Medicaid-covered care are not similarly targeted by the Defund Provision and are not prohibited from receiving Medicaid funds as a result.

141. The Defund Provision targets Planned Parenthood Members for unequal treatment because of their association with PPFA and each other. Such unequal treatment burdens Planned Parenthood Members' fundamental right to free association under the First Amendment. In particular, the Defund Provision singles Planned Parenthood Members out for unequal treatment based on their association with other providers of lawful abortion and PPFA, and based on their advocacy for access to sexual and reproductive health care, including abortion. The Defund Provision does not similarly restrict other abortion providers' associational rights.

142. The Defund Provision does not further a compelling government interest. And even if it did, it does not use the least restrictive available means.

143. The Defund Provision also does not further an important government interest. And even if it did, it is not substantially related to achievement of an important governmental objective.

144. Moreover, the Defund Provision does not even bear a rational relationship to any legitimate government interest. The Defund Provision's ban on reimbursing Planned Parenthood Members for their non-abortion-related care does not rationally relate to a possible government interest. Far from a legitimate interest, the Defund Provision is animated solely by animus—a moral disapproval of the political views and lawful activities of Planned Parenthood. *See Romer v. Evans*, 517 U.S. 620, 632 (1996).

145. The Defund Provision violates the equal protection component of the Due Process Clause of the Fifth Amendment by irrationally singling out Planned Parenthood for unfavorable

treatment. *See Planned Parenthood of Cent. N.C. v. Cansler*, 877 F. Supp. 2d 310, 325-28 (M.D.N.C. 2012).

146. Accordingly, Plaintiffs are entitled to a declaratory judgment, judgment awarding them preliminary and permanent injunctive relief, attorneys' fees, costs, and any other relief the Court deems just and appropriate.

COUNT THREE
FIRST AMENDMENT: RETALIATION

147. Paragraphs 1 through 129 above are incorporated and reasserted as if fully set forth herein.

148. "Congress shall make no law … abridging the freedom of speech." U.S. Const. amend. I. Congress cannot "punish or suppress disfavored expression." *Nat'l Rifle Ass'n v. Vullo*, 602 U.S. 175, 188 (2024). Nor can it retaliate against such expression. *See Lozman v. City of Riviera Beach*, 585 U.S. 87, 90 (2018); *see also Pierce v. Cotuit Fire Dist.*, 741 F.3d 295, 301 (1st Cir. 2014) ("It is well established that political discrimination … , including retaliation for a contrary political opinion, violates the freedom of belief and association protected by the First Amendment.").

149. To state a First Amendment retaliation claim, a plaintiff must allege that it "'engaged in constitutionally protected conduct,'" was "'subjected to an adverse [government] action,'" and that "'the protected conduct was a substantial or motivating factor in the adverse action'" such that retaliatory animus was the but-for cause of the injury. *Gattineri v. Town of Lynnfield*, 58 F.4th 512, 514-15 (1st Cir. 2023).

150. PPFA and its Members engage in First Amendment protected activity. They do so by advocating for access to sexual and reproductive health care, including the right to safe and

legal abortion. Members associate with PPFA and one another to speak and act collectively where appropriate, and in furtherance of their common goals, exercising the associative right "implicit in the right to engage in activities protected by the First Amendment." *Roberts v. United States Jaycees*, 468 U.S. 609, 622 (1984).

151. The Defund Provision qualifies as an action adverse to PPFA and its Members. Quite simply, the Defund Provision punishes Planned Parenthood Members for their association with each other and with PPFA by excluding them from Medicaid reimbursements that they would otherwise be qualified to receive. Stopping the flow of millions of dollars in reimbursements for provided medical services would "'deter a reasonably hardy individual'" from associating with Planned Parenthood or from advocating for the sexual and reproductive rights and other causes that Planned Parenthood champions. *McCue v. Bradstreet*, 807 F.3d 334, 339 (1st Cir. 2015).

152. That is by design. The Defund Provision is obviously motivated by more than the provision of abortion, otherwise it would cover all abortion providers and not just target Planned Parenthood. The history and context of the Defund Provision make clear that it treats Planned Parenthood Members—each of which is an independent corporation with its own leadership, board, finances, and autonomous operations— differently from other health care providers. The statute plainly defunds Planned Parenthood Members because of their participation in the nation's most high-profile membership association of abortion providers, known for its advocacy for abortion rights and access across the country. Context confirms the retaliatory animus underlying the Defund Provision. Over a decade worth of failed attempts and public statements demonstrate that Congress passed the Defund Provision to target Planned Parenthood.

153. Accordingly, Plaintiffs are entitled to a declaratory judgment, judgment awarding them preliminary and permanent injunctive relief, attorneys' fees, costs, and any other relief the Court deems just and appropriate.

COUNT FOUR
REQUEST FOR DECLARATORY JUDGMENT
(on behalf of PPAU and the Non-Qualifying Members)

154. Paragraphs 1 through 129 above are incorporated and reasserted as if fully set forth herein.

155. The Defund Provision excludes "prohibited entities" from receiving federal Medicaid funds. The statute defines "prohibited entities" to include entities that, among other things, provide abortion services and received more than $800,000 in Medicaid reimbursements in fiscal year 2023.

156. Planned Parenthood Members that do not provide abortions or did not receive over $800,000 in Medicaid funds in fiscal year 2023 are not themselves "prohibited entities" under the Defund Provision.

157. Under the plain meaning of the statute, Planned Parenthood Members that do not provide abortions or did not receive over $800,000 in Medicaid funds in fiscal year 2023 are not "affiliates, subsidiaries, successors, or clinics" of "prohibited entities" under Section 71113.

158. Planned Parenthood Members are not owned or controlled by PPFA or by each other.

159. Therefore, the Defund Provision does not apply to Planned Parenthood Members that do not provide abortions or did not receive over $800,000 in Medicaid funds in fiscal year 2023.

160. Despite this, there is a substantial risk that Defendants will interpret the Defund Provision to prohibit these Non-Qualifying Members from receiving Medicaid funding solely based on their association with PPFA and other Members, even though they do not meet the statutory criteria for exclusion. Interpreting the Defund Provision to cover the Non-Qualifying Members is aligned with President Trump's stated goal to "defund" Planned Parenthood, and so is a predictable interpretation for the Defendants to adopt.

161. Because of this risk, the Non-Qualifying Members that do not independently satisfy the requirements of "prohibited entities" under the Defund Provision will nonetheless be forced to cease seeking Medicaid reimbursement or else risk being subject to enforcement based on allegations that they filed unlawful claims for reimbursement.

162. The Non-Qualifying Members seek a declaration that the Defund Provision does not apply to Planned Parenthood Members that do not provide abortion services or did not receive more than $800,000 in Medicaid reimbursements during fiscal year 2023, and that such Non-Qualifying Members are not considered "prohibited entities" or "affiliates, subsidiaries, successors, or clinics" thereof under the Act.

163. Accordingly, the Non-Qualifying Members are entitled to a declaratory judgment, judgment awarding them preliminary and permanent injunctive relief, attorneys' fees, costs, and any other relief the Court deems just and appropriate.

COUNT FIVE
UNCONSTITUTIONAL PENALTY ON CONSTITUTIONALLY PROTECTED ACTIVITY UNDER THE FIRST AMENDMENT
(PLED IN THE ALTERNATIVE TO COUNT FOUR)
(on behalf of PPAU and the Non-Qualifying Members)

164. Paragraphs 1 through 129 above are incorporated and reasserted as if fully set forth herein.

165. The Defund Provision violates the First Amendment to the United States Constitution by imposing an unconstitutional condition on the Non-Qualifying Members that do not provide abortion services or did not receive over $800,000 in Medicaid funds in fiscal year 2023, including but not limited to Plaintiff PPAU.

166. To the extent the Defund Provision purports to deny those Non-Qualifying Members a benefit—eligibility for federal Medicaid funding—based on their association with PPFA and other Members, it impermissibly infringes upon the Non-Qualifying Members' First Amendment right of association. If interpreted to apply to the Non-Qualifying Members, the Defund Provision would require the Non-Qualifying Members to surrender their right to associate with PPFA and other Members in order to maintain their eligibility for Medicaid reimbursements. Absent disassociation from PPFA and the Members, the Non-Qualifying Members would be barred from receiving federal funds if any of their purported "affiliates" provide abortions and received more than $800,000 in Medicaid funds in fiscal year 2023—even though they themselves do not meet that definition.

167. There is "implicit in the right to engage in activities protected by the First Amendment a corresponding right to associate with others in pursuit of a wide variety of political, social, economic, educational, religious, and cultural ends." *United States Jaycees*, 468 U.S. at 622. The Defund Provision purports to deny Plaintiff PPAU and other Non-Qualifying Members the ability to associate with PPFA and other Members in their work in advocating for, and providing, sexual and reproductive health care for all, including abortion.

168. Accordingly, the Non-Qualifying Members are entitled to a declaratory judgment, judgment awarding them preliminary and permanent injunctive relief, attorneys' fees, costs, and any other relief the Court deems just and appropriate.

COUNT SIX
FIFTH AMENDMENT: VAGUENESS
(PLED IN THE ALTERNATIVE TO COUNT FOUR)
(on behalf of PPAU and the Non-Qualifying Members)

169. Paragraphs 1 through 129 above are incorporated and reasserted as if fully set forth herein.

170. Since "clarity in regulation is essential," the Due Process Clause of the Fifth Amendment "requires the invalidation of laws that are impermissibly vague." *FCC v. Fox Television Stations, Inc.*, 567 U.S. 239, 253 (2012). First, laws must "give the person of ordinary intelligence a reasonable opportunity to know what is prohibited." *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972). And second, laws must not invite "arbitrary and discriminatory enforcement." *Id.*

171. Laws that "abut[] upon sensitive areas of basic First Amendment freedoms" must rigorously adhere to these requirements to ensure ambiguity does not chill protected speech or association. *Grayned*, 408 U.S. at 109; *see also Fox*, 567 U.S. at 253-54 ("When speech is involved, rigorous adherence to those requirements is necessary to ensure that ambiguity does not chill protected speech.").

172. The Defund Provision is impermissibly vague as applied to certain Planned Parenthood Members. While the statute leaves no doubt that it targets Planned Parenthood, the statute does not clarify whether it reaches each and every Planned Parenthood Member. The statute defines "prohibited entity" to include "affiliates, subsidiaries, successors, and clinics," yet the

statute leaves those terms undefined. It is ambiguous whether the statute reaches Planned Parenthood Members who do not provide abortions. It is also ambiguous whether the statute reaches Members who did not receive more than $800,000 from Medicaid in the 2023 fiscal year. In short, the Defund Provision leaves certain Planned Parenthood Members guessing—at great risk to themselves and their patients—whether their association with PPFA and other Planned Parenthood Members will jeopardize their participation in Medicaid.

173. To the extent the Defund Provision's prohibition may encompass the Non-Qualifying Members, the Defund Provision implicates their associational freedoms that the First Amendment protects. Where a statute implicates First Amendment rights, it must rigorously adhere to the vagueness doctrine's notice requirement and its prohibition on enabling arbitrary or discriminatory enforcement.

174. The Defund Provision does not reasonably specify whom it regulates. As such, it does not provide reasonable notice, and it delegates to enforcement officials the discretion to determine who is eligible to receive millions in Medicaid reimbursements. Therefore, the Defund Provision is void for vagueness as applied to the Non-Qualifying Members who do not provide abortions and/or who did not receive more than $800,000 from Medicaid in the 2023 fiscal year.

175. Accordingly, the Non-Qualifying Members are entitled to a declaratory judgment, judgment awarding them preliminary and permanent injunctive relief, attorneys' fees, costs, and any other relief the Court deems just and appropriate.

RELIEF REQUESTED

WHEREFORE, Plaintiffs request that this Court

a) Issue a declaratory judgment that the Defund Provision violates the Bill of Attainder Clause of the United States Constitution;

b) Issue a declaratory judgment that the Defund Provision violates the equal protection component of the Due Process Clause of the Fifth Amendment to the United States Constitution;

c) Issue a declaratory judgment that the Defund Provision violates the First Amendment to the United States Constitution;

d) Issue a declaratory judgment that the Defund Provision does not apply to Planned Parenthood Members that do not provide abortions or did not receive more than $800,000 in Medicaid funds in fiscal year 2023, and/or else that the Defund Provision is unconstitutional as applied to the Non-Qualifying Members because it violates their freedom of association and is unconstitutionally vague;

e) Issue a declaratory judgment that the Defund Provision is not a lawful or proper basis for terminating Planned Parenthood Members from Medicaid programs.

f) Issue a declaratory judgment that all Planned Parenthood Members may continue to seek and obtain reimbursements for eligible care provided to Medicaid recipients, and that requests for such reimbursements shall constitute lawful claims under Planned Parenthood Members' respective Medicaid Provider Agreements;

g) Issue a declaratory judgment that Planned Parenthood Members are entitled to retain Medicaid reimbursements for eligible care provided to Medicaid recipients while an injunction is in place, even if such injunction is later reversed;

h) Issue temporary, preliminary, and permanent injunctive relief, without bond, restraining the enforcement, operation, and execution of the Defund Provision, by enjoining Defendants, their agents, employees, appointees, successors, and anyone acting in concert or participation with Defendants from enforcing, threatening to enforce, or otherwise applying the provisions of the Defund Provision against any Planned Parenthood Members, even if the injunction is later reversed, or for seeking and retaining Medicaid reimbursement for such services;

i) Order Defendants, their agents, employees, appointees, successors, and anyone acting in concert or participation with Defendants to take all steps necessary to ensure that Medicaid reimbursements continue to be disbursed to Planned Parenthood Members in the customary manner and timeframes, including reimbursements for services provided while an injunction is in place;

j) Retain jurisdiction after judgment for the purpose of resolving any future disputes over the effect of any injunctive relief this Court may issue, including if injunctive relief is granted and later reversed;

k) Award Plaintiffs their costs, attorney's fees, and other expenses pursuant to the Equal Access to Justice Act, 28 U.S.C. § 2412(d); and

l) Grant such further relief as this Court deems just and proper.

Dated: July 7, 2025

Respectfully submitted,

/s/ Sharon K. Hogue

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**Application for pro hac vice forthcoming*

Counsel for Plaintiffs

CERTIFICATE OF SERVICE

Counsel for Plaintiffs certify that they have submitted the foregoing document with the clerk of court for the District of Massachusetts, using the electronic case filing system of the Court. Counsel for Plaintiffs hereby certify that they have served all parties electronically or by another manner authorized by Fed. R. Civ. P. 5(b)(2).

Dated: July 7, 2025

/s/ Sharon K. Hogue
Sharon K. Hogue, BBO# 705510

JS 44 (Rev. 10/20)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

Planned Parenthood Federation of America, Inc.; Planned Parenthood League of Massachusetts; Planned Parenthood Association of Utah

(b) County of Residence of First Listed Plaintiff New York County
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*

Sharon K. Hogue, Wilmer Cutler Pickering Hale and Dorr LLP, 60 State St., Boston, MA 02109, (617) 526-6000

DEFENDANTS

ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; MEHMET OZ, in his official capacity as ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES

County of Residence of First Listed Defendant District of Columbia
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☐ 3 Federal Question *(U.S. Government Not a Party)*
- ☒ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark
- ☐ 880 Defend Trade Secrets Act of 2016

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit (15 USC 1681 or 1692)
- ☐ 485 Telephone Consumer Protection Act
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☒ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing *(Do not cite jurisdictional statutes unless diversity)*:
U.S. Const. art. 1, section 9, cl. 3, amends. I and V

Brief description of cause:
Constitutional claims arising from exclusion of Planned Parenthood Members from Medicaid

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:
JURY DEMAND: ☐ Yes ☒ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE _____ DOCKET NUMBER _____

DATE 07/07/2025

SIGNATURE OF ATTORNEY OF RECORD /s/ Sharon K. Hogue

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP A165 JUDGE _____ MAG. JUDGE _____

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

1. **Title of case (name of first party on each side only)** Planned Parenthood Federation of America, Inc., et al. v. Robert F. Kennedy, Jr., in his official capacity as Secretary of the U.S. Department of Health and Human Services, et al.

2. **Category in which the case belongs based upon the numbered nature of suit code listed on the civil cover sheet. (See local rule 40.1(a)(1)).**

☐ I. **160, 400, 410, 441, 535, 830*, 835*, 850, 880, 891, 893, R.23, REGARDLESS OF NATURE OF SUIT.**

☐ II. **110, 130, 190, 196, 370, 375, 376, 440, 442, 443, 445, 446, 448, 470, 751, 820*, 840*, 895, 896, 899.**

☑ III. **120, 140, 150, 151, 152, 153, 195, 210, 220, 230, 240, 245, 290, 310, 315, 320, 330, 340, 345, 350, 355, 360, 362, 365, 367, 368, 371, 380, 385, 422, 423, 430, 450, 460, 462, 463, 465, 480, 485, 490, 510, 530, 540, 550, 555, 560, 625, 690, 710, 720, 740, 790, 791, 861-865, 870, 871, 890, 950.**

***Also complete AO 120 or AO 121. for patent, trademark or copyright cases.**

3. **Title and number, if any, of related cases. (See local rule 40.1(g)). If more than one prior related case has been filed in this district please indicate the title and number of the first filed case in this court.**

4. **Has a prior action between the same parties and based on the same claim ever been filed in this court?**
YES ☐ **NO** ☑

5. **Does the complaint in this case question the constitutionality of an act of congress affecting the public interest? (See 28 USC §2403)**
YES ☑ **NO** ☐

If so, is the U.S.A. or an officer, agent or employee of the U.S. a party?
YES ☑ **NO** ☐

6. **Is this case required to be heard and determined by a district court of three judges pursuant to title 28 USC §2284?**
YES ☐ **NO** ☑

7. **Do <u>all</u> of the parties in this action, excluding governmental agencies of the United States and the Commonwealth of Massachusetts ("governmental agencies"), residing in Massachusetts reside in the same division? - (See Local Rule 40.1(d)).**
YES ☑ **NO** ☐

A. **If yes, in which division do <u>all</u> of the non-governmental parties reside?**
Eastern Division ☑ **Central Division** ☐ **Western Division** ☐

B. **If no, in which division do the majority of the plaintiffs or the only parties, excluding governmental agencies, residing in Massachusetts reside?**
Eastern Division ☐ **Central Division** ☐ **Western Division** ☐

8. **If filing a Notice of Removal - are there any motions pending in the state court requiring the attention of this Court? (If yes, submit a separate sheet identifying the motions)**
YES ☐ **NO** ☐

(PLEASE TYPE OR PRINT)

ATTORNEY'S NAME Sharon K. Hogue
ADDRESS 60 State St., Boston, MA 02109
TELEPHONE NO. (617) 526-6000

(CategoryForm11-2020.wpd)

EXHIBIT 1

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.; PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS; and PLANNED PARENTHOOD ASSOCIATION OF UTAH, Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; MEHMET OZ, in his official capacity as ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES; and CENTERS FOR MEDICARE & MEDICAID SERVICES, Defendants.	Case No. _____

DECLARATION OF KIMBERLY CUSTER
IN SUPPORT OF PLAINTIFFS' EMERGENCY MOTION FOR A
TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

I, Kimberly Custer, declare and state as follows:

1. I am employed by Planned Parenthood Federation of America, Inc. ("PPFA") as Executive Vice President and Senior Advisor to the President of PPFA. In this role, I am responsible for, among other things, advising the President on a variety of strategic and operational objectives, leading digital health strategy development and planning, and engaging with the independent members of Planned Parenthood Federation of America (each, a "Member" and collectively, the "Members" or "Membership"). I am involved in developing strategies to address the short- and long-term needs of PPFA's Members nationwide, and support them in their core mission of ensuring access to sexual and reproductive health care services, including abortion, regardless of income, insurance, gender identity, sexual orientation, or race.

2. I previously served as Executive Vice President and Chief Federation Engagement & Impact Officer from 2021 to 2025. In this role, I developed, led, and implemented PPFA's strategic framework for coordinating with Members and oversaw teams responsible for having a federation-wide impact. From 2015 to 2021, I served as Executive Vice President, Health Care Division overseeing PPFA's health care-related programs and strategies in support of Members, including those related to medical services, health education, research, contraceptive equity, health care operations, business analytics, accreditation, and evaluation for PPFA's Members, as well as support for Member governance and leadership. Before taking on these roles at PPFA, I worked at two different Planned Parenthood Member organizations. I served as Chief Executive Officer of Planned Parenthood Keystone from 2004 to 2015, and as Vice President of Community Affairs at Planned Parenthood of Orange and San Bernardino Counties from 1997 to 2004.

3. I am over the age of eighteen, and this declaration is based on my personal knowledge, a review of PPFA's business records, and the knowledge I have acquired in the course

of my service and duties with PPFA and Planned Parenthood Members. If called and sworn as a witness, I could and would testify competently thereto.

4. As discussed more fully below, Section 71113 of An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14 (the "Defund Provision"), if allowed to remain in effect, will be devastating to the patients who rely on Planned Parenthood Member health centers for their sexual and reproductive health care. Indeed, the Defund Provision is already forcing Members to turn away patients enrolled in Medicaid. Nationwide, 51% of Planned Parenthood Member patients rely on Medicaid for their health care. And more than one-third of Members' total revenue is from Medicaid reimbursement for services the Members provide. Because the Defund Provision bars Planned Parenthood Members from receiving federal reimbursement under the Medicaid program for the care provided to these patients, if the Defund Provision is allowed to remain in effect, Planned Parenthood Members will have to severely curtail the services they provide to many of their low-income patients. Those patients will face great difficulty in finding, and in many cases will be unable to find, alternative providers of evidence-based sexual and reproductive health care in their communities. Because many Planned Parenthood Members will also have to close health centers and/or reduce the hours they serve patients, the care of many other Planned Parenthood Member patients will be jeopardized.

5. The Defund Provision will have a severe and disproportionate impact on Members' most vulnerable patient groups—low-income patients, individuals who live in rural and/or medically underserved areas, and communities of color. Other providers will not be able to fill the gap in services that will result, and many individuals who rely on Planned Parenthood Members will be deprived of the ability to obtain high-quality and often life-saving health care. At a minimum, over a million patients will lose their preferred health care provider and will face serious disruptions and discontinuities in their health care.

6. The Defund Provision presents an existential threat to PPFA and its Members and their patients. PPFA estimates that a substantial number of Planned Parenthood Member health centers could eventually close if the Defund Provision remains in effect and if Members continue to be unable to provide care through the Medicaid program.

I. PPFA'S MISSION AND STRUCTURE

7. PPFA is a 501(c)(3) not-for-profit corporation organized under the laws of New York. PPFA is a membership organization whose forty-seven Members are non-profit health care providers with health centers in forty-seven states and the District of Columbia, as well as a telehealth presence in all fifty states. PPFA does not itself provide health care services but supports its health care-providing Members in a variety of ways.

8. Because PPFA is not a health care provider, it does not participate in Medicaid.

9. Planned Parenthood Members are separately incorporated and independently governed 501(c)(3) non-profit corporations, each with its own CEO; governance structure, including a board of directors; staff; books; and operations. Each Planned Parenthood Member provides health care and educational services directly to the public in a distinct geographic area.

10. As part of their membership rights, PPFA Members elect PPFA's board of directors; approve changes to PPFA's bylaws and membership standards; approve PPFA's long-range goals; and determine the amount each Member pays in annual dues to PPFA.

11. As a condition of membership, PPFA requires each Member to agree to meet its membership standards (outlined in PPFA's bylaws and set by the Membership) and provides them with support and services to ensure that they are able to provide high-quality care consistent with evidence-based standards.

12. PPFA and its Members share a mission of ensuring that regardless of income, insurance, gender identity, sexual orientation, or race, people can receive high-quality, inclusive,

and comprehensive sexual and reproductive health care; providing related educational services; promoting research on sexual and reproductive health; and advocating for public policies that guarantee access to such services. For more than a century, millions of patients have turned to Planned Parenthood Members for vital health care services, sex education, and sexual health information.

13. PPFA provides support, leadership, and guidance to its Members to ensure that Members are able to provide high-quality health care and educational services directly to the public. For example, PPFA administers accreditation standards for the Membership, promulgates certain shared medical standards and guidelines, and provides leadership around certain shared policy and program initiatives. PPFA also provides practical support such as technical assistance and consultant service, programmatic grants, and fundraising support. While Members receive some grant and other funding through PPFA—an average of less than 7% annually for each Member—overall, the vast majority of each Member's revenue comes from sources other than PPFA.

14. PPFA licenses the use of the Planned Parenthood name and well-known trademark to each Member.

15. PPFA membership is important to Members' ability to fulfill their missions. The Planned Parenthood name sends a powerful message to the community that the Member stands for certain values and provides high-quality health care and educational services in furtherance of the shared Planned Parenthood mission. Planned Parenthood Members are viewed in communities throughout the country as providing nonjudgmental, welcoming, and compassionate care to patients seeking health care, including sexual and reproductive health care.

16. In addition to maintaining separate corporate structures, PPFA and its Members maintain separate finances and day-to-day operations. For example, PPFA and each Member

maintain separate general ledgers and file taxes separately from one another. Each has separate payrolls and employee rosters, and PPFA has no role in its Members' respective staffing or employment decisions.

17. Their structural independence means that no Member has control over the operations or decision-making processes of another. The actions or policies of one Planned Parenthood Member do not legally or operationally bind the others.

18. Similarly, PPFA does not exercise control over any Member, or vice versa.

19. Working in furtherance of the shared Planned Parenthood mission, PPFA and its Members also advocate to shape the national, state, and local landscape to create the most favorable conditions for people everywhere to have equitable access to the vital sexual and reproductive health care, including abortion, provided by Planned Parenthood Members and other non-profit sexual and reproductive health care providers. Hearing directly from Planned Parenthood Member patients and with the backing of 19 million supporters, PPFA and its Members are uniquely situated and bear a special responsibility to lead the defense against attacks on sexual and reproductive health care and to shape a national narrative that shifts public opinion while advancing the policies and systems that will preserve and improve access to care—for Planned Parenthood Member patients and all people seeking sexual and reproductive health care. Separately, each Member may have a related 501(c)(4) tax-exempt entity with its own board that works in furtherance of the Planned Parenthood mission, and PPFA has a related 501(c)(4) organization called Planned Parenthood Action Fund. These independent, separately incorporated non-profit social welfare organizations each engage in education, advocacy, and limited electoral activities that work to further the Planned Parenthood mission.

II. HEALTH CARE SERVICES PROVIDED BY PLANNED PARENTHOOD MEMBERS

20. Collectively, Planned Parenthood Members have health centers in forty-seven states and the District of Columbia and a telehealth presence in all fifty states.

21. Taken together, PPFA's forty-seven Members provide sexual and reproductive health care to more people in the United States than any other provider. Planned Parenthood Members provide medical services through nearly 600 health centers throughout the nation, serving more than two million patients each year. One out of every three women and one in ten men nationally has received care from a PPFA Member at least once in their lifetime; this number is even higher among individuals with Medicaid, 43% of whom have received services from a Member health center.[1] In 2021 alone, one in ten reproductive-aged Medicaid beneficiaries who received family planning services went to a Planned Parenthood Member health center for that care.[2] And in 2020, Planned Parenthood Member health centers served 33% of the total contraceptive clients served by safety-net providers—roughly 1.6 million people.[3] PPFA Members play a particularly important role in providing sexual and reproductive and other health care to low-income people.

22. All PPFA Members offer a wide range of family planning services and reproductive health care, although the specific services that PPFA Members offer vary depending on the needs of the communities in which they operate and the resources available. Members typically provide

[1] Brittni Frederiksen et al., *Major Federal and State Funding Cuts Facing Planned Parenthood*, KFF (May 15, 2025), https://www.kff.org/womens-health-policy/issue-brief/major-federal-and-state-funding-cuts-facing-planned-parenthood/.

[2] Brittni Frederiksen et al., *The Impact of Medicaid and Title X on Planned Parenthood*, KFF (Apr. 16, 2025), https://www.kff.org/medicaid/issue-brief/the-impact-of-medicaid-and-title-x-on-planned-parenthood/.

[3] Guttmacher Inst., *Federally Qualified Health Centers Could Not Readily Replace Planned Parenthood* (June 4, 2025), https://www.guttmacher.org/news-release/2025/federally-qualified-health-centers-could-not-readily-replace-planned-parenthood.

contraception (including long-acting reversible contraceptives ("LARCs")), contraceptive counseling, physical exams, cancer screenings, gender-affirming hormone therapy, testing and treatment for sexually transmitted infections ("STIs"), pregnancy testing and counseling, vasectomies, colposcopies, abortion where legal, and health education services.

23. During the federal fiscal year 2023, Planned Parenthood Members served approximately 2.08 million patients and provided more than 9.4 million total services.[4] The care Planned Parenthood Members that year included over 2.2 million birth control services, more than 5.1 million STI tests, over 400,000 abortions, and over 426,000 cancer screenings and prevention services.[5] Abortions comprise a small fraction—approximately 4%—of Members' services nationwide.[6] Members also reached approximately 1.3 million people through education programming, outreach, and trainings.[7]

24. PPFA Members have a special mission to provide sexual and reproductive health care, including abortion, to historically underserved patients and communities. In many communities, a Planned Parenthood Member health center is the only place that a patient can turn to for high-quality, compassionate, and low-cost (or free) reproductive health care. Sixty-four percent of Planned Parenthood Member health centers are located in rural areas, Health Professional Shortage Areas, or Medically Underserved Areas.[8]

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[4] Planned Parenthood Fed'n of Am., *2023-2024 Annual Report*, at 6, 23 (2024), https://www.plannedparenthood.org/uploads/filer_public/ec/6d/ec6da0d6-98e5-4278-8d11-99a5cba8e615/2024-ppfa-annualreport-c3-digital.pdf [hereinafter PPFA Annual Report].

[5] *Id.* at 6, 23.

[6] *Id.* at 22.

[7] *Id.* at 14.

[8] Health Professional Shortage Areas—as designated by the Health Resources and Services Administration, an agency of the U.S. Department of Health and Human Services—are designated as having shortages of primary medical care, dental, or mental health providers. Medically Underserved Areas have a shortage of primary care health services for residents

25. Of the Planned Parenthood Member patients who report their income, 65% have incomes at or below 150% of the federal poverty level.[9]

26. Planned Parenthood Member health centers play a critical role in serving communities of color, and in many cases are the only health centers providing sexual and reproductive health care in the communities they serve. In the 2023 to 2024 reporting period, approximately 34% of Planned Parenthood Members' patients were white, 27% were Latino/a, 17% were Black, 12% did not disclose their race or their race was unknown, 4% were Asian American/Pacific Islander, 0.5% were American Indian/Alaskan Native, 4% were another race, and 2% were multiracial. As this data shows, Planned Parenthood Members serve a disproportionate number of patients of color as compared to the U.S. population.[10]

27. Patients choose to receive care from Planned Parenthood Members for numerous reasons.

28. Planned Parenthood Member health centers offer a range of comprehensive services that many other providers do not, such as LARCs. LARCs are the most effective methods of preventing pregnancy—they are more than 99% effective,[11] leading to a dramatic reduction in unintended pregnancies. Once in place, they can prevent pregnancy for up to twelve years. Member

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within a geographic area. Health Res. & Servs. Admin., *What Is Shortage Designation?* (June 2023), https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation.

[9] *See generally* U.S. Dep't of Health & Hum. Servs., Office of the Assistant Sec'y for Plan. & Evaluation, *2025 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii),* https://aspe.hhs.gov/sites/default/files/documents/dd73d4f00d8a819d10b2fdb70d254f7b/detailed-guidelines-2025.pdf (last visited July 5, 2025) (the 2025 poverty level for a single individual is $15,650 and is $32,150 for a family of four).

[10] *See generally* U.S. Census Bureau, *Quick Facts*, https://www.census.gov/quickfacts/fact/table/US/PST045223 (last visited July 5, 2025).

[11] Am. Coll. of Obstetricians & Gynecologists, *FAQs: Long-Acting Reversible Contraception (LARC): Intrauterine Device (IUD) and Implant*, https://www.acog.org/womens-health/faqs/long-acting-reversible-contraception-iud-and-implant (last visited July 5, 2025).

health centers typically offer three categories of LARCs: birth control implants, hormonal intrauterine devices ("IUDs"), and non-hormonal IUDs. They also typically provide LARCs in a single visit to reduce barriers to access, whereas many providers require patients to return for a second visit.

29. Many Planned Parenthood Member health centers have language services for patients who are not proficient in English, a service that other health clinics are often not able to provide. Many Member health centers also have bilingual or multilingual staff, as well as access to interpretation and translation services. PPFA and its Members often provide educational materials in English, Spanish, and other languages commonly spoken by the patients served in particular areas.

30. Planned Parenthood Member health centers have staff trained to help patients experiencing intimate partner violence ("IPV"), and clinicians are trained to screen patients for IPV. The training includes ways to identify if a patient is experiencing reproductive or sexual coercion, such as attempts to impregnate a partner against their will, control outcomes of a pregnancy, coerce a partner to have unprotected sex, and interfere with contraceptive methods.[12] Clinicians are also specifically trained to screen for signs of abuse or coercion during telehealth visits. PPFA and its Members also provide educational resources related to healthy relationships, consent, and sexual assault.

31. Planned Parenthood Members are viewed in communities throughout the country as providing nonjudgmental, welcoming, culturally-sensitive, and compassionate care to patients seeking health care, including sexual and reproductive health care. Topics of this sort can be highly

[12] Am. Coll. Obstetricians & Gynecologists, *ACOG Committee Opinion Number 554: Reproductive and Sexual Coercion*, 121 Obstetrics & Gynecology 411 (2013).

sensitive for patients, some of whom may find it difficult to discuss issues of sexuality or to seek treatment for reproductive- or sex-related conditions, such as STIs.

32. Indeed, because of their concerns about privacy and being judged, many individuals use Planned Parenthood Members as their provider for sexual and reproductive health care services even when they use other providers for their other health care needs. Moreover, Planned Parenthood Members' expertise and specialization in family planning, evidence-based practices, and technology often make them the top choice for individuals seeking high-quality medical care.

33. Planned Parenthood Member health centers are also often much more convenient for and accessible to their patients than other providers of sexual and reproductive health care—even when such alternative providers are available, which is often not the case. Planned Parenthood Members are usually able to see patients quickly and in many cases on a walk-in basis. In contrast, patients seeking sexual and reproductive health care services often face long wait times for appointments at other providers. Wait times can be a serious barrier to care, especially for low-income patients, many of whom have inflexible schedules due to work and/or child care responsibilities.

34. Most Planned Parenthood Member health centers offer extended (early morning, evening, or weekend) hours. The majority offer evening appointments at least one day per week, as well as weekend appointments. Again, these extended hours are very important to patients who have inflexible schedules and have difficulty in attending medical appointments during the traditional 9-to-5 workday.

35. In addition, all Planned Parenthood Members offer online scheduling for appointments and provide health services (including appointments for contraceptives) via telehealth, which makes such services more accessible to patients with disabilities, in remote areas, who lack access to reliable transportation, and/or who have inflexible schedules. In the 2023

federal fiscal year, Planned Parenthood Member health centers provided over 296,000 telehealth appointments to patients.

36. In recent years, many Planned Parenthood Members have served an increased and critically important role with respect to the provision of care to LGBTQ+ individuals. LGBTQ+ people face lower rates of health insurance coverage, higher rates of HIV/AIDS and cancer, and higher rates of discrimination from medical providers.[13] All Planned Parenthood Members offer HIV prevention tools like pre- or post-exposure prophylaxis ("PrEP" and "PEP," respectively), a daily drug regimen to help prevent HIV. As of the 2024 federal fiscal year, 90% of Member health centers offer PrEP, and 77% offer PEP. Many Planned Parenthood Member health centers have programs for LGBTQ+ youth and allies, providing safe and supportive environments that allow youth to get the information and support they need to make healthy decisions and feel comfortable in their identities.

37. Planned Parenthood Member health centers are a critical source of care for transgender people nationwide. They are often the only place that transgender individuals can receive care without facing discrimination or judgment. Members provide gender-affirming hormone therapy to treat gender dysphoria as well as other services in a trans-affirming manner.

38. PPFA and its Members provide education and information to Members' patients and the general public about sexual and reproductive health, risks, and preventive measures, reaching approximately 1.3 million individuals[14] in person with education and information in their communities—and even more people online. Planned Parenthood Member educators also train

[13] Planned Parenthood Fed'n of Am., *This is Who Planned Parenthood Is* (Sept. 2017), https://www.plannedparenthood.org/uploads/filer_public/16/3f/163fe02e-2c2d-4bcf-92f5-63386b4c4065/who_we_are_lgbtq_community_september_2017.pdf.

[14] PPFA Annual Report, *supra* note 4, at 14.

teachers, school staff, and other youth-serving professionals within their communities on critical topics such as age-appropriate youth pregnancy prevention and STI prevention.

39. Planned Parenthood Members have been at the forefront of responding to recent public health crises. For example, in response to the COVID-19 pandemic, Members expanded their use of telehealth, including for medication abortion. They made changes to workflows and operations to minimize or eliminate physical contact with patients and time in the health center, including the adoption of telehealth for various components of the medication abortion care process, such as pre-abortion counseling and follow up appointments. And after the U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* led to the implementation of abortion bans in many states, Planned Parenthood Members responded to the abortion access crisis by opening health centers in states where abortion remained legal close to the borders of states with abortion bans, as well as by expanding staffing and hours in access states.

40. PPFA and its Members are committed to supporting the advancement of research and technology in sexual and reproductive health, and are well situated to do so because of the millions of patients Members serve and the range of care they provide. In the 2024 PPFA fiscal year, 69% of Members participated in at least one research study for a total of 73 unique studies between PPFA and its Members. For example, PPFA and its Members have led and participated in research concerning contraceptive methods, such as contraceptive patches, IUDs, and emergency contraception, as well as human papillomavirus ("HPV") vaccine, sharing this research in journal articles and presentations at conferences ranging from the American Public Health Association to the American Congress of Obstetricians and Gynecologists.

III. PLANNED PARENTHOOD MEMBERS' SERVICE TO MEDICAID PATIENTS

41. The Medicaid program provides health coverage for eligible low-income families and individuals. The majority of the funding for Medicaid is provided by the federal government,

but the program is administered at the state level; the amount of state funding and the exact way in which the program is administered varies from state to state. In general, the program operates by reimbursing health care providers for health care services that they have provided to enrolled Medicaid patients.

42. Medicaid reimbursement rates vary by state but are generally well below Medicare and commercial insurance rates, so many providers do not accept Medicaid patients or effectively limit the number of Medicaid patients they see.[15] In many states, Medicaid reimbursement rates are significantly lower than the actual cost of delivering care.

43. Despite this, Planned Parenthood Members see Medicaid patients as part of their longstanding commitment to providing quality health care to underserved patients. As part of that commitment, Planned Parenthood Members participate in Medicaid programs in every state where they are able, a total of forty-six of forty-seven Members across forty-three states.[16] No Member limits the number of Medicaid patients that it will see. Approximately 51% of Planned Parenthood Members' patients rely on Medicaid for their health care, and half of visits to Planned Parenthood Member health centers are covered by Medicaid.

44. Medicaid reimbursements for reproductive health care services, preventive care screenings, and treatment make up a large portion of Planned Parenthood Members' revenue. In

[15] Cindy Mann & Adam Striar, *How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity, and Cost*, Commonwealth Fund (Aug. 17, 2022), https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact.

[16] The Member who participated only in the Texas Medicaid program is not able to provide care through Medicaid. Texas terminated Planned Parenthood Members from its Medicaid program; the termination was enjoined for several years based on the district court's determination that there was not "even a scintilla of evidence" supporting the terminations, but that injunction was subsequently reversed on procedural grounds. *See Planned Parenthood of Greater Tex. Fam. Plan. & Preventative Health Servs., Inc. v. Smith*, 236 F. Supp. 3d 974, 998 (W.D. Tex. 2017), *vacated sub nom. Planned Parenthood of Greater Tex. Fam. Plan. & Preventative Health Servs., Inc. v. Kauffman*, 981 F.3d 347 (5th Cir. 2020).

federal fiscal year 2023, in the aggregate, more than one-third of Members' total revenue was from Medicaid reimbursements for health care services the Members provided. That year, more than half of PPFA's Members received 25% or more of their health care revenue in the form of Medicaid reimbursements. Because of the great unmet need for high-quality Medicaid providers of sexual and reproductive health care, some of those Members received the vast majority (over three quarters) of their health services revenue from Medicaid reimbursements that year.[17]

45. Federal law has long prohibited federal funds, including Medicaid funds, being used for abortion (except in narrow circumstances of rape, incest, and when the life of the pregnant person is in danger). This provision of federal law—commonly known as the Hyde Amendment—means that Medicaid does not cover abortion, except within these narrow exceptions. Accordingly, Planned Parenthood Members do not receive Medicaid reimbursements or any other federal funds for abortion services (other than in those very narrow circumstances).

46. For many Planned Parenthood Member patients enrolled in Medicaid, a Planned Parenthood Member is their only health care provider. In a survey of patients of publicly-funded clinics, like Planned Parenthood Member health centers, for the years 2015 to 2019, two-thirds of patients reported that the clinics were their primary source of medical care.[18] And based on a survey of 725 patients of two Planned Parenthood Member health centers in Kentucky and

[17] While the federal government regulates the services for which federal Medicaid funds can be used, states can, and in many cases do, cover additional services through their Medicaid programs with state-only funds. While the vast majority of Members' Medicaid reimbursements are for services reimbursed using federal funds—i.e., the federal funding that will be lost under the Defund Provision—the percentages above also include reimbursements that Members receive for services reimbursed using state-only funds.

[18] Jennifer J. Frost et al., *Trends and Differentials in Receipt of Sexual and Reproductive Health Services in the United States: Services Received and Sources of Care, 2006–2019*, Guttmacher Inst. (June 2021), https://www.guttmacher.org/sites/default/files/report_pdf/sexual-reproductive-health-services-in-us-sources-care-2006-2019.pdf.

Louisiana, 60% did not have a regular source of health care besides a Planned Parenthood Member, and nearly 40% reported "instability" with their health insurance.[19]

IV. THE DEVASTATING IMPACT OF THE DEFUND PROVISION ON PPFA, ITS MEMBERS, AND MEMBERS' PATIENTS

47. I have reviewed the Defund Provision and understand that it bars certain Planned Parenthood Members from receiving federal Medicaid reimbursements for the care provided to Medicaid patients. If it is not enjoined, the Defund Provision will have a devastating impact on PPFA, its Members, and the patients and communities that Members serve.

48. This is not the first time the federal government has attempted to "defund Planned Parenthood." In 2017, the House introduced a bill initially targeting entities that provided abortions and received more than $350 million in Medicaid funds in fiscal year 2014 for exclusion from Medicaid. Collectively, Members received over $350 million in Medicaid funds that year. My understanding is that the 2017 House bill would not have defunded any abortion providers other than Planned Parenthood Members.[20]

49. The Defund Provision is already affecting patients at Planned Parenthood Member health centers. It is forcing some Members to turn away patients enrolled in Medicaid; to attempt to refer them to other providers; or to offer Medicaid patients (who, by criteria of the program, have low incomes) the option to pay out-of-pocket for services where state law allows. Paying for care may be impossible for some Medicaid patients and may force some to forego other necessities such as paying for food or rent.

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[19] Anna Newton-Levinson et al., *Influences on Women's Care Seeking at Planned Parenthood Health Centers in Two Southern States*, 31 Women's Health Issues 485 (2021).

[20] *See* Paige Winfield Cunningham, *Planned Parenthood Defunded for One Year Under GOP Health Bill*, Wash. Post (May 4, 2017), https://www.washingtonpost.com/news/powerpost/wp/2017/05/04/planned-parenthood-defunded-for-one-year-under-gop-health-bill/.

50. If the Defund Provision is not enjoined, many Medicaid patients will no longer be able to receive care at their chosen provider. In many cases, they will not be able to access equivalent care elsewhere, and in some cases, they may not be able to access health care at all. This is especially true for those who already face systemic barriers to getting care and who have worse health outcomes as a result. This particularly includes groups who face systemic discrimination and barriers to economic advancement—e.g., people of color, LGBTQ+ people, and women—all of whom Members disproportionately serve and who are more likely than others to have low incomes and qualify for Medicaid coverage.

51. Even those patients who are still able to access care at a Member health center could experience longer wait times and increased costs of health care.

52. I understand that proponents of the Defund Provision have argued that there will not be a reduction in access to reproductive health care because services will be available through community health centers or other publicly funded health care providers, such as federally qualified health centers. But it is clear that other health centers will not fill the gaps left by the closure and reduced capacity of Planned Parenthood Member health centers.[21]

53. Many existing publicly funded health care providers, such as public health departments, do not provide the services that Planned Parenthood Members provide, and certainly do not provide the full range of high-quality services for lower-income patients with minimal wait times, convenient hours, and access for people with limited English proficiency. Moreover, these providers are stretched to their capacity now, and cannot serve the more than one million people who will no longer be able to obtain care at Planned Parenthood Member health centers as a result of the Defund Provision. Nor do such providers offer the nonjudgmental, welcoming, culturally-sensitive, and compassionate care that Planned Parenthood Members provide their patients.

[21] Guttmacher Inst., *supra* note 3.

54. The Defund Provision will have a dramatic and devastating impact on PPFA Members' ability to provide necessary and often life-saving health care to their patients throughout the country, especially their most vulnerable patients who are in need of affordable, high-quality health care. Moreover, in many cases the Defund Provision will also require Members to reduce hours at their health centers or close some health centers altogether—with serious adverse consequences for the many patients served there, Medicaid and non-Medicaid alike.

55. Of the nearly 600 Planned Parenthood Member health centers, a substantial number could be at risk of closing if the Defund Provision is allowed to remain in effect, many of which are located in Medically Underserved Areas, primary care Health Professional Shortage Areas, or rural areas. At minimum it creates grave instability at a time when as many as 17 million people could lose access to Medicaid or other health insurance.[22]

56. The Defund Provision would be particularly devastating to patients in Medically Underserved Areas, many of whom would likely not be able to obtain health care from alternative providers in their communities. Even those who are fortunate enough to be able to obtain care from an alternative provider will likely face delays in care, as other providers scramble to serve the more than one million Planned Parenthood Members' patients who may have to go elsewhere for health care. Delays and gaps in the care that Planned Parenthood Members provide are particularly devastating, as they can lead to undetected STIs, undetected cancers, complications in pregnancies, missed use of contraception, and other serious health conditions.

57. Due to the demographics of Planned Parenthood Members' patient populations, barring Members from receiving federal Medicaid reimbursements would have a disproportionate

[22] Cynthia Cox, *About 17 Million More People Could be Uninsured due to the Big Beautiful Bill and Other Policy Changes*, KFF (July 1, 2025), https://www.kff.org/quick-take/about-17-million-more-people-could-be-uninsured-due-to-the-big-beautiful-bill-and-other-policy-changes/.

adverse impact on communities of color. Such communities already face barriers to quality health care that would only increase if Planned Parenthood Member health centers—many of which are one of the only providers in communities where they are located—were forced to close or reduce services.

58. The Defund Provision comes on the heels of the Trump administration's ending of Title X funding for many Planned Parenthood Members. Title X is a federally funded family-planning grant program that enables grantees to provide certain family planning services to low-income patients based on a sliding fee scale. Title X services include some, but not all, of the reproductive health care services that are available under Medicaid, and the criteria for eligibility to receive services under Title X are different from those under Medicaid. Several Planned Parenthood Members received more than 15% of their health services revenue from Title X until recently. Without Title X funds to fill some of the coverage gaps for patients with low incomes caused by the Defund Provision, the impacts will be even greater than if just one revenue stream had been cut.

59. The Defund Provision will harm PPFA's mission of ensuring access to comprehensive sexual and reproductive health care for all individuals, regardless of their ability to pay. Although PPFA does not directly operate health centers, all of its Members do, and—at minimum—they will be forced to reduce services to their patients as a result of being excluded from receiving federal funds under Medicaid. That injury to PPFA's Members also harms PPFA's mission, and PPFA will suffer substantial reputational and operational injury if the Defund Provision is not enjoined.

A. Harm to Certain Planned Parenthood Members

60. In addition to the harms to Planned Parenthood League of Massachusetts, Planned Parenthood Association of Utah, and the Planned Parenthood Members in California, all Planned

Parenthood Members enrolled in Medicaid will suffer revenue losses as a result of the Defund Provision, and their Medicaid patients may not be able to access services at a Member health center.

61. Eight Members will lose between 25 and 49% of their revenue as a result of the Defund Provision. For example, in the federal fiscal year 2023, Planned Parenthood of Wisconsin ("PPWI") received 49% of its total revenue—$17.6 million—from Medicaid. In the 2024 federal fiscal year, Medicaid patients made more than 35,000 visits to PPWI, representing more than half of the total visits at PPWI that year. The Guttmacher Institute estimates that publicly-supported clinics in Wisconsin would have to more than double their caseloads to meet the needs of patients currently served by PPWI.[23] Furthermore, 21% of Medicaid beneficiaries who received family planning services in Wisconsin went to PPWI.[24]

62. An additional ten Members will lose between 15 and 24% of their total revenue, and eleven Members will lose less than 15% of their total revenue because of the Defunding Provision.

63. Based on my understanding of the definition of in the Defund Provision, ten Members who are enrolled in Medicaid do not independently meet the definition of "prohibited entity" because they do not provide abortions, did not receive more than $800,000 in Medicaid reimbursements for federal fiscal year 2023, or both. Three of these Members (Planned Parenthood Gulf Coast, Planned Parenthood Greater Texas, and Planned Parenthood of Tennessee and North Mississippi) do not provide abortions because it is not legal in any state where their health centers are located. Other Members, including Plaintiff Planned Parenthood Association of Utah, received less than $800,000 in Medicaid reimbursements in federal fiscal year 2023.

[23] Guttmacher Inst., *supra* note 3.

[24] Frederiksen et al., *supra* note 2.

64. For example, in federal fiscal year 2023, Planned Parenthood of Delaware ("PPDE") received approximately $273,000 in Medicaid funding, or 6% of its total revenue. In 2024, roughly 20% of PPDE patients were enrolled in Medicaid or Medicare.[25]

B. The Experiences in States That Have Excluded Planned Parenthood Members from Medicaid or Other Government Health Care Programs Preview the Dire Harms to Come.

65. Multiple states have weaponized their animus towards Planned Parenthood and excluded Members from their Medicaid programs or from other publicly-funded health care programs—to the detriment of their own citizens. This state-level defunding has shown how harmful the exclusion of Planned Parenthood Members from Medicaid actually is—painting a dangerous picture of what will happen if the Defund Provision is not enjoined.

66. For example, beginning in 2011, Texas lawmakers took steps to remove Planned Parenthood Members in the state from receiving state and federal funds to provide health care. In 2011, Texas cut $73 million from a joint federal-state family planning program, through which Planned Parenthood Member health centers served more than 40% of participants.[26]

67. In 2012, Texas tried to block patients from getting care at Planned Parenthood Member health centers and other abortion providers in its federally-funded Medicaid family planning program—Women's Health Program ("WHP")—while still retaining federal funding for that program. After this attempt was blocked by the Obama administration in 2013, Texas

[25] Planned Parenthood of Del., *2024 Annual Report* (May 12, 2025), https://www.plannedparenthood.org/uploads/filer_public/b8/99/b8997f4e-0f93-4be5-aff7-26657e808b2f/2024_annual_report_final.pdf.

[26] Planned Parenthood Fed'n of Am., *The Harm of Defunding Planned Parenthood Health Centers* (Apr. 2025), https://www.plannedparenthood.org/uploads/filer_public/60/22/6022aa2f-caed-4946-966f-7186b9751e3c/defunding_state_cases_20_pdf.pdf?. Texas targeted Planned Parenthood by targeting "providers 'affiliated' with clinics that perform abortions. (By this logic, because some Planned Parenthood clinics provide abortions, none of them can receive state money.)." Emily Ramshaw, *Lawmakers Could Restore Family Planning Funds*, Tex. Trib. (Dec. 7, 2012, 6:00 AM), https://www.texastribune.org/2012/12/07/lawmakers-could-restore-family-planning-funds/.

lawmakers instead opted to forego federal funding altogether for the state's family planning program and were thus able to block WHP enrollees from getting care at Planned Parenthood Member health centers and from other abortion providers in the state.[27]

68. In 2020, the Trump administration approved federal funding for a new version of WHP called Healthy Texas Women ("HTW") and allowed Texas to continue excluding Planned Parenthood Members from the program. And in 2021, Texas blocked Medicaid enrollees from getting care at Planned Parenthood Member health centers by terminating all three Members in Texas from the state Medicaid program.[28]

69. All of these actions led to worse health outcomes for Texans, including less access to contraceptive care, STI testing, and cancer screening, as well as the closure of Member health centers.[29] Whereas 90% of HTW enrollees were able to access care in 2011 when Planned Parenthood Members were still in the program, that number dropped to 59% in 2023.[30] Birth control use also declined by 56% during that same period.[31]

70. Politicized attacks on Planned Parenthood Members in other states have also harmed patients. In 2017, Iowa, like Texas, ended its federally-funded Medicaid family planning waiver program, replacing it with a state-funded program that prevented Medicaid enrollees from

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[27] Planned Parenthood Fed'n of Am., *supra* note 26. Like the 2011 action, the 2012 action targeted clinics "affiliated with abortion providers." Alana Rocha, *Judge's Order Allows Planned Parenthood to Remain in Women's Health Program*, Tex. Trib. (Oct. 26, 2012, 2 PM), https://www.texastribune.org/2012/10/26/planned-parenthood-suing-over-affiliate-ban-rule/.

[28] Planned Parenthood Fed'n of Am., *supra* note 26.

[29] *Id*.

[30] *See, e.g.,* Every Texan, *Limited Access: How Provider Exclusion Has Reshaped Care for Texas Women* 1 (May 2025), https://everytexan.org/wp-content/uploads/2025/06/ProviderExclusion_Report_EveryTexan_May2025.pdf.

[31] *Id*.

accessing family planning providers who perform abortions, including Planned Parenthood Members. Four Planned Parenthood Member health centers closed as a result of the defunding.[32]

71. After Indiana enacted a 2011 law that barred Planned Parenthood Member health centers from receiving federal STI prevention funding, five Member health centers were forced to close, including one in Scott County. By 2015, Scott County had an unprecedented HIV outbreak, leading then-Governor Mike Pence to declare a public health emergency.[33]

72. When Kansas blocked non-profit family planning centers, including Planned Parenthood Member health centers, from receiving Title X funds in 2011, more than 14,000 people lost access to birth control, cancer screenings, STI tests, annual pelvic exams, and other care. As a result of the cuts, one Member health center in Hays, Kansas was forced to close, leaving the area without a dedicated family planning provider.[34]

73. In 2011, Tennessee diverted Title X funds from a Planned Parenthood Member in Shelby County—an area that ranks especially high in unintended teen pregnancies—to a faith-based entity that did not have the same capacity to see patients. By 2012, family planning services provided to women in Shelby County had dropped by 93%.[35]

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[32] Planned Parenthood Fed'n of Am., *supra* note 26; *see also, e.g.,* Michaela Ramm, *Iowa's Family Planning Service Use Plummets 85 Percent After Switch to New Program*, Gazette (Dec. 10, 2019, 5:31 PM), https://www.thegazette.com/health-care-medicine/iowas-family-planning-service-use-plummets-85-percent-after-switch-to-new-program/.

[33] Planned Parenthood Fed'n of Am., *supra* note 26; *see also, e.g., Indiana Governor Declares Public Health Emergency to Battle Worst HIV Outbreak in State History*, ABC News (Mar. 26, 2015, 10:28 AM), https://abcnews.go.com/Health/indiana-hit-worst-hiv-outbreak-state-history/story?id=29921662.

[34] Planned Parenthood Fed'n of Am., *supra* note 26; *see, e.g.,* Roxana Hegeman, *Feds Push Back on States Targeting Planned Parenthood Funds*, Associated Press (Sept. 24, 2016), https://apnews.com/domestic-news-domestic-news-general-news-03c09aa8420a4bce98a413449129d2f8 ("The number of Kansans who received Title X services fell from 38,461 in 2011 to 24,047 in 2015 — a decrease of more than 37 percent, according to HHS.").

[35] Planned Parenthood Fed'n of Am., *supra* note 26; *see also, e.g.,* Tara Culp-Ressler, *Defunding Planned Parenthood Caused Women's Services to Drop by 93 Percent in Tennessee County*,

VI. THE DEFUND PROVISION WILL ALSO HAVE DIRE IMPACTS ON ABORTION ACCESS OUTSIDE THE MEDICAID PROGRAM.

74. As providers of a comprehensive range of sexual and reproductive health care, Planned Parenthood Members offer safe and legal abortion services in states where abortion is legal. Planned Parenthood Members collectively provide approximately 40% of all of the abortions performed in the United States. Providing abortion is critical to PPFA's and its Members' mission of ensuring access to sexual and reproductive health care, including abortion.

75. PPFA and its Members, along with national, state, and local Planned Parenthood 501(c)(4) social welfare organizations, have long been at the forefront of the movement for sexual and reproductive rights, including access to abortion. As the nation's leading advocates for sexual and reproductive health care and education, Planned Parenthood organizations advocate at the federal, state, and local levels to protect and expand access to services and information. Before Congress, PPFA has pushed to codify the rights to abortion and contraception, block abortion bans, and repeal the Hyde Amendment.[36] PPFA has also advocated for access to emergency contraception and medication abortion.[37] Planned Parenthood Members, and when appropriate

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Think Progress (Sept. 6, 2012, 6:46 PM), https://archive.thinkprogress.org/defunding-planned-parenthood-caused-womens-services-to-drop-by-93-percent-in-tennessee-county-bc0562be7a7f/.

[36] Planned Parenthood Fed'n of Am., *Tell the Senate: Vote YES on the Women's Health Protection Act*, https://www.plannedparenthood.org/get-involved/campaigns/congress-protect-safe-legal-abortion (last visited July 5, 2025); Planned Parenthood Fed'n of Am., *House Passes Right to Contraception Bill, Critical Step in Protecting Essential Right* (July 21, 2022), https://www.plannedparenthood.org/about-us/newsroom/press-releases/house-passes-right-to-contraception-bill-critical-step-in-protecting-essential-right; Planned Parenthood Fed'n of Am., *Planned Parenthood President on 45th Anniversary of the Hyde Amendment* (Sept. 30, 2021), https://www.plannedparenthood.org/about-us/newsroom/press-releases/planned-parenthood-president-on-45th-anniversary-of-the-hyde-amendment; Planned Parenthood Fed'n of Am., *Planned Parenthood Denounces House Committee Passage of National 20-Week Abortion Ban* (Jan. 30, 2014), https://www.plannedparenthood.org/about-us/newsroom/press-releases/planned-parenthood-denounces-house-committee-passage-national-20-week-abortion-ban.

[37] Planned Parenthood Fed'n of Am., *Planned Parenthood Applauds FDA Expansion of Access to Over-The-Counter Emergency Contraception* (Nov. 6, 2014), https://www.plannedparenthood.org/about-us/newsroom/press-releases/planned-parenthood-applauds-fda-expansion-of-access-to-over-the-counter-emergency-contraception; Planned Parenthood Fed'n of Am., *FDA Reaffirms*

PPFA, are active litigants fighting to secure abortion access and rights for their patients in federal and state courts across the country. Planned Parenthood Action Fund, a related 501(c)(4) organization, advocates for policies that protect care for Planned Parenthood Member patients and seeks to hold members of Congress accountable to their constituents through its congressional scorecard, communicating with and activating constituents to educate their lawmakers about the importance of sexual and reproductive health care.[38] Planned Parenthood Members and their related 501(c)(4) organizations play similar roles, respectively, in advocating for sexual and reproductive rights in states across the nation. Additionally, together with Members' related 501(c)(4) organizations, Planned Parenthood Action Fund has actively supported successful campaigns for reproductive freedom ballot initiatives since the Supreme Court's ruling in *Dobbs*. Separately, Planned Parenthood Action Fund and other national and local Planned Parenthood advocacy and political organizations, work to elect federal, state, and local elected officials who will support reproductive freedom and access to abortion.

76. As explained above, Medicaid does not cover abortion (except under narrow circumstances authorized by federal law) and accordingly, Members do not receive any federal funds for providing these abortions.

77. Many Planned Parenthood Member health centers primarily provide contraception, physical exams, STI testing and treatment, gender-affirming hormone therapy, and cancer screenings but also provide abortions. Although Planned Parenthood Member health clinics provide abortion through separate funding streams and entirely outside the federally-subsidized

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Safety of Mifepristone, Approves New Label for Medication Abortion (Mar. 30, 2016), https://www.plannedparenthood.org/about-us/newsroom/press-releases/fda-reaffirms-safety-of-mifepristone-approves-new-label-for-medication-abortion.

[38] Planned Parenthood Action Fund, *Congressional Scorecard*, https://www.plannedparenthoodaction.org/congressional-scorecard (last visited July 5, 2025).

Medicaid program, the closure of clinics because of the Defund Provision will also impact the various non-Medicaid services Planned Parenthood Members offer, including abortion—since a clinic that no longer exists obviously cannot provide any services at all. Thus, the Defund Provision will force Planned Parenthood Members to provide fewer abortion services in states where abortion is legal because they will have to close health centers and reduce staff.

78. If Planned Parenthood Members were to stop performing abortions, people across the Nation would face drastic hardship in obtaining safe and high-quality abortion care. There is no way that the remaining abortion providers in this country could find the capacity to meet the need for abortion services no longer met by Planned Parenthood Members. Moreover, discontinuing of abortion services would be inconsistent with the core mission of Members and PPFA to ensure access to sexual and reproductive health care, including abortion, for all.

79. Cutting off access to abortion puts pregnant people at risk and strips people of their rights to build their families and futures as they see fit. When abortion is not accessible, women and children suffer the most. States with more abortion restrictions tend to have poorer health outcomes for women and children than other states, including higher rates of maternal and infant mortality.[39] According to a recent study, after *Dobbs*, mothers living in a state that banned abortion were three times more likely to die during pregnancy, childbirth, or soon after giving birth.[40] Patients who are unable to access a wanted abortion are more likely to receive public assistance

[39] *See* Ibis Reprod. Health & Ctr. for Reprod. Rights, *Evaluating Priorities: Measuring Women's and Children's Health and Well-being Against Abortion Restrictions in the States* 23 (2017), https://ibisreproductivehealth.org/sites/default/files/files/publications/Evaluating%20Priorities%20August%202017.pdf.

[40] Gender Equity Pol'y Inst., *The State of Reproductive Health in the United States* (Jan. 19, 2023), https://thegepi.org/wp-content/uploads/2024/05/GEPI-State-of-Repro-Health-Report-US.pdf.

and lack full-time employment six months after being unable to obtain an abortion.[41] These economic consequences impact individuals, their families, and their communities for years to come. Furthermore, in states with laws impeding access to abortion or limiting the number of abortion clinics, both women and men have a decreased likelihood of transitioning from unemployment to employment.[42] In contrast, when given access to abortion, women's health outcomes and economic security improve. Women living in states with policies that support women's access to health care have higher earnings and are more integrated into the workforce than women in other states.[43]

80. This abortion care crisis is made worse by the fact that nineteen states have an abortion ban in effect.[44] As a result, health centers across these states have shuttered, making it more difficult for patients to access a variety of other health care, including preventative health services. In 2024, 155,000 people traveled out of their home state for abortion care.[45] The closure of additional Planned Parenthood Member health centers as a result of the Defund Provision will

[41] Diane Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who are Denied Wanted Abortions in the United States*, 108 Am. J. Pub. Health 407 (2018).

[42] Kate Bahn et al., *Linking Reproductive Health Care Access to Labor Market Opportunities for Women*, Ctr. for Am. Progress (Nov. 21, 2017), https://www.americanprogress.org/issues/women/reports/2017/11/21/442653/linking-reproductive-health-care-access-labor-market-opportunities-women/.

[43] *Id*. *See also* Asha Banerjee, The Economics of Abortion Bans, Econ. Pol'y Inst. (Jan. 18, 2023), https://www.epi.org/publication/economics-of-abortion-bans/ ("While the effect of abortion denial is overwhelmingly negative economically, mentally, and physically, there is also strong evidence for the flip side of this argument: that access to abortion is associated with positive economic outcomes, including lower rates of teen births and teen marriages").

[44] KFF, *Abortion in the United States Dashboard* (June 2, 2025), https://www.kff.org/womens-health-policy/dashboard/abortion-in-the-u-s-dashboard.

[45] Guttmacher Inst., *Guttmacher Institute Releases Data on State of Residence of US Abortion Patients Traveling for Care in 2024* (June 24, 2025), https://www.guttmacher.org/news-release/2025/guttmacher-institute-releases-data-state-residence-us-abortion-patients-traveling.

only make it harder for patients to access abortion in states where it is legal, as well as other health services.

81. As discussed above, defunding Planned Parenthood Members from Medicaid puts a substantial number of Planned Parenthood Member health centers at risk of closure. The vast majority of the health centers at risk of closure are in states where abortion is legal. An overwhelming majority of the Planned Parenthood Member health centers at risk of closure provide abortion care, meaning it will be much harder to get an abortion, in addition to other sexual and reproductive health care.

VII. INJUNCTION BOND

82. PPFA, a not-for-profit organization, is not capable of posting a bond in the amount of the federal funds that its Members receive in Medicaid reimbursements. If PPFA were required to post an injunction bond in such an amount, it would be foreclosed from pursuing judicial relief on behalf of its Members.

I declare under penalty of perjury that the foregoing is true and correct. Executed on July 6, 2025.

Kimberly Custer

EXHIBIT 2

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.; PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS; and PLANNED PARENTHOOD ASSOCIATION OF UTAH, Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; MEHMET OZ, in his official capacity as ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES; and CENTERS FOR MEDICARE & MEDICAID SERVICES, Defendants.	Case No. _____

DECLARATION OF DOMINIQUE LEE
IN SUPPORT OF PLAINTIFFS' EMERGENCY MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

1. I am currently employed by Planned Parenthood League of Massachusetts ("PPLM") as President and Chief Executive Officer. PPLM is a not-for-profit corporation registered to do business in Massachusetts. I have served in this role since September of 2023. I have also served at other Planned Parenthood affiliates, including as Chief Operating Officer of Planned Parenthood Mar Monte, which operates thirty-five health centers in California and Nevada and is the largest affiliate in the nation. In that role, I led enterprise-wide implementation of telehealth services across thirty-five health centers, serving more than 250,000 patients annually.

This system-wide rollout ensured the continuation of care during the COVID-19 pandemic and required rapidly adapting clinical operations to shifting public health guidance, patient needs, and regulatory requirements to preserve access to essential reproductive and primary health services. I have nearly twenty years of experience in sexual and reproductive health care, including direct oversight of clinical operations, regulatory compliance, and access to abortion and contraceptive services. I have led responses to rapidly changing landscapes, including state restrictions, funding threats, and operational challenges across multiple states. My work has included ensuring continuity of care under emergency conditions, navigating Medicaid and commercial payer systems, and advising on operational implications of federal and state policy changes. I hold a Master of Business Administration from Northwestern, Kellogg School of Management, as well as a Master of Public Health from Dartmouth College, where I currently serve as an Adjunct Lecturer in the Institute for Health Policy and Clinical Practice.

2. In my role as PPLM's President and Chief Executive Officer, I am responsible for PPLM's management. As such, I am familiar with the types of care we provide, patient demographics, operations, and staff needs and concerns. I lead PPLM's executive team, interface with its Board of Directors, and am responsible for a wide array of operational and strategic decisions.

3. I am over the age of eighteen and have personal knowledge of the matters herein or have acquired such knowledge by personally examining the business records kept in the normal course of business by PPLM. If called upon to testify, I could and would testify to the facts in this declaration.

4. As I explain below, Section 71113 of An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14 (the "Defund Provision") will cause immediate and irreparable harm

to PPLM and the patients it serves—including and especially people with low incomes who lack alternative access to expert, reliable reproductive health care. If PPLM remains prohibited from receiving federal Medicaid reimbursements, its health centers' operations will be immediately and potentially irrevocably upended and our patient relationships threatened as we face losing 40% of our gross operating revenue. PPLM and its patients are already experiencing harm in the few days since the Defund Provision has gone into effect. When Section 71113 went into effect on July 4, we immediately began preparing for the impact this would have when our health centers opened on Monday. We have nearly 150 scheduled appointments for Medicaid patients across our health centers on July 7 and July 8 alone, and have been reaching out to inform these patients they cannot use their Medicaid coverage for services at PPLM. We are discussing options with patients to try to ensure their access to care, but we know that many patients cannot afford to self-pay for their care and will not be able to get timely, high-quality care at another provider that accepts Medicaid. PPLM has already had to disrupt and reorganize dozens of workflows that direct, among other things, patient intake, general patient communication, and billing. We have translated new communications materials and worked with community partners to shore up referral systems–all while trying to reassure our staff that they will still have jobs next week.

5. PPLM clinics in recent years have served a significant portion of patients who seek reproductive healthcare from publicly funded clinics in Massachusetts, including 54% of Massachusetts patients that received family planning services through Medicaid. Because alternative providers in the State are already significantly overstretched, PPLM's ejection from the Medicaid program will have seriously adverse public health consequences for the State as a whole,

including a precipitous rise in unwanted pregnancies, sexually transmitted infections ("STIs"), and abortions.[1]

6. Furthermore, unless an injunction is quickly granted, the Defund Provision will likely have a significant effect on PPLM's financial viability. While the exact financial impact is still being assessed, early estimates indicate that the Defund Provision will jeopardize 35–40% of our annual health care revenue. This could force PPLM to make substantial reductions to services, programs, and staffing, potentially up to 20–25%, and may ultimately put our health centers at risk of closure. We have determined that these reductions will need to start within three months absent injunctive relief.

I. ORGANIZATION

7. PPLM is a nonprofit corporation organized under the laws of the Commonwealth of Massachusetts, with its principal office located in Boston, Massachusetts.

8. PPLM is exempt from taxation under Section 501(c)(3) of the Internal Revenue Code. Each of its clinics is an essential community provider, 45 C.F.R. § 156.235, that is primarily engaged in family planning services, reproductive health, and related medical care.

9. PPLM's mission is to ensure that every person in the State has access to sexual and reproductive health care and education no matter who they are, where they live, or who they love. Our work is informed by research, powered by advocacy, and conducted with compassion and respect. For ninety-four years, PPLM has been the leading provider of high-quality, comprehensive, compassionate, safe, and confidential family planning, reproductive health care,

[1] Usha Ranji et al., *5 Key Facts About Medicaid and Family Planning*, KFF (May 29, 2025), https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-and-family-planning/#:~:text=The%20Medicaid%20program%20has%20a,for%20other%20health%20care%20services.

and education for all people in Massachusetts. PPLM's staff and network of clinics work to ensure that families and communities have the resources they need to achieve positive reproductive health outcomes, regardless of their ability to pay for services.

10. PPLM is an independently incorporated entity with its own CEO, Board of Directors, and management. PPLM has its own infrastructure and approximately 200 staff members manage the day-to-day operations of our health centers and educational services. As the premier provider of sexual and reproductive health care in Massachusetts, PPLM implements operational and advocacy strategies to meet the reproductive health needs in the state. This includes PPLM's ASPIRE Center for Sexual And Reproductive Health which engages in clinical and social science research, professional education, and clinical training independently and in partnership with academic institutions in Massachusetts, and teaching hospitals, especially in the greater Boston area.

11. In order to better serve its mission, PPLM also is a member of Planned Parenthood Federation of America, Inc. ("PPFA"). PPLM pays annual dues to PPFA to maintain its membership status. As a member of PPFA, PPLM receives the right to use the Planned Parenthood name and service mark and to participate in programs organized by PPFA. PPLM's membership in PPFA helps to serve PPLM's core mission. PPFA lends valuable advice and technical support in areas including clinical research, compliance with the medical standards and guidelines, revenue management, development, public affairs, communications, and advocacy. In addition, because only providers who meet PPFA's stringent accreditation standards are permitted to use the Planned Parenthood name, patients know that they can trust Planned Parenthood members for expert, nonjudgmental care.

II. PPLM'S ROLE IN PROMOTING PUBLIC HEALTH

12. PPLM provides a range of sexual, reproductive, and wellness care at its four physical health centers in Boston (the Greater Boston Health Center), Marlborough (The Metro West Health Center), Springfield (the Western Massachusetts Health Center), and Worcester (the Central Massachusetts Health Center), and through its virtual health center that offers telehealth services via phone and video.

13. PPLM's health centers offer birth control, pregnancy testing and prenatal referrals, testing and treatment for STIs, Pre-Exposure Prophylaxis ("PrEP"), Post-Exposure Prophylaxis ("PEP"), clinical breast exams, breast and cervical cancer screenings, colposcopy and biopsy, condyloma treatment, and gender affirming care.

14. PPLM also provides critical health education to its patients, including education about breast and cervical cancer screening, diagnosis, follow-up, and referral to medical specialists in the community. PPLM develops health educational services for the general public as well, offering age-appropriate and medically accurate sexual education programs in public schools and in partnership with community-based organizations that provide guidance and support. Furthermore, by offering peer education and lay health advisor programs, PPLM trains youth and adults to respond to cultural and linguistic barriers that often keep members of their communities from seeking and receiving the health care they need.

15. PPLM delivers health care to more than 30,000 unique patients each year. In 2024 alone, PPLM provided patients with more than 20,500 birth control methods, including nearly 5,000 long-acting reversible contraceptives ("LARCs"), which are the most effective forms of birth control. In that same year, PPLM performed more than 65,000 STI tests, which comprises a substantial portion of the STI tests performed in PPLM's service areas.

16. Three of PPLM's health centers are in communities classified by the federal government as Medical Care Health Professional Shortage Areas ("HPSAs") for individuals with low incomes, and a substantial part of its education services are provided to individuals in communities experiencing significant health disparities.[2] Unlike most family planning providers in its service areas, PPLM's health centers offer early morning, limited evening, and weekend hours. Additionally, we offer walk-in appointments and same-day contraception, including highly effective LARCs—services that are often not offered by other providers in the area—and without the burdensome wait times or multiple visits that are often encountered elsewhere.

17. Because PPLM's health care centers offer same-day and walk-in visits for most services and for urgent care needs, they serve as an alternative to the emergency room for many of their patients. For example, patients come to PPLM's health centers for treatment following miscarriages and for treatment of urinary tract infections. By offering those services, PPLM alleviates the burden on emergency rooms and primary care providers.

18. In addition, PPLM manages an active clinical training program through partnerships with local academic institutions, hospitals, and other organizations. This program includes both clinical observations and hands-on rotations for medical students, residents, fellows, and advanced practice clinicians to train in all of the services PPLM provides. We are also in year three of our ASPIRE Center's sexual and reproductive health residency program for nurse practitioners, physician assistants, and certified nurse midwives. The residency program is based at our Central Massachusetts health center in Worcester and is supported by funding from the Massachusetts Department of Public Health.

[2] HPSAs are designated by the Health Resources and Services Administration ("HRSA"), an agency of the U.S. Department of Health and Human Services ("HHS"), as having shortages of primary medical care, dental, or mental health providers.

19. PPLM also partners with Brigham and Women's Hospital to co-host the MassGeneralBrigham-Harvard Medical School Complex Family Planning Fellowship (MGB-HMS CFP). The MGB-HMS CFP program is a nationwide training program for obstetrician-gynecologists to receive subspecialty clinical training in abortion and contraception care, training in clinical research methods and public health, and exposure to policy and advocacy work. This Fellowship program works to create the next generation of leaders in the research and provision of sexual and reproductive health care, with specific expertise in serving patients with complex issues. Our professional education programs are vital to the provision of sexual and reproductive health care in the state, serving as a pipeline of trained providers to areas in Massachusetts where there is a shortage of sexual and reproductive health care providers, including Springfield and Worcester.

20. In 2024, PPLM referred more than 2,100 patients to other providers for a variety of types of care, including diagnosis and management of chronic diseases including cancer, diabetes, cardiovascular disease, mental health, obstetric and breast specialist care, human immunodeficiency virus ("HIV") care, infertility, and dermatology. Many of those patients initially came to PPLM health care centers for other medical needs, including family planning services, and would likely not have received treatment for their illnesses if not for the PPLM staff, who were able to accurately diagnose their conditions and connect them with appropriate medical professionals.

21. A core part of PPLM's mission is to deliver reproductive health care to individuals with low incomes, including individuals who rely on Medicaid. The vast majority of PPLM's patients are economically disadvantaged and come from at-risk communities. Two of PPLM's four clinics—the Greater Boston and Central Massachusetts Health Centers—are in communities

classified as Medically Underserved Areas, which are areas designated by HHS as having major shortages in primary health service providers relative to the health care needs of the community. As noted above, Worcester, where the Central Massachusetts Health Center is located, and Springfield, where the Western Massachusetts Health Center is located, are both designated by HHS as primary care HPSAs.

22. In patient surveys, PPLM is consistently highly ranked as a leading provider of sexual and reproductive health care. Specifically, our Medicaid patients have scored PPLM an average of 93/100 in overall patient experience, overall access, and convenience of our hours. They have also scored our care providers an average of 95/100 and 96/100 when asked if the services they were offered met their needs. In particular, patients often report that they choose PPLM because of the confidential and nonjudgmental care we provide. Many patients come to PPLM out of concern that their local or family provider may judge them or fail to respect their privacy.

23. The Commonwealth of Massachusetts is in great need of the services PPLM provides. According to the last comprehensive study published in 2020 by the Guttmacher Institute, the nation's leading research organization regarding reproductive health care, there are 1,498,680 women of reproductive age (13–44) in Massachusetts, of which 947,850 are in need of contraceptive services and supplies.[3] Of those, 332,670 women need publicly supported contraceptive services, because they either have an income below 250% of the Federal Poverty Level (68%) or are younger than 20 years of age (32%). In Massachusetts, 34% of all pregnancies

[3] Blades N et al., *Publicly Supported Family Planning Services in the United States, 2020—Tables and Appendix Tables*, Guttmacher Inst. (May 2025), https://www.guttmacher.org/sites/default/files/report_downloads/publicly-supported-fp-services-us-2020tables-and-appendix-tables.pdf.

are unintended, indicating an ongoing and urgent need for accessible family planning and reproductive health services.[4]

24. Based on 2022 data from Massachusetts Department of Public Health, the birth rate for female youth aged 15–19 is 5.7 per 1,000.[5] The need for PPLM's services is particularly acute in Worcester, Springfield, and Marlborough, where the birth rates (per 1000) of female youth aged 15–19 are 9.5, 19.8, and 16.3 respectively.[6] Further, for youth under the age of 18 in Worcester and Springfield 27.8% and 23.5% (respectively) received inadequate prenatal care, based on the Adequacy of Prenatal Care Utilization Index.[7]

25. Between 2021 to 2023, the state rates of chlamydia, gonorrhea, and HIV increased, and there was only a slight decrease in confirmed and probable infectious syphilis cases.[8] In areas such as Hampden County, the rates for chlamydia, gonorrhea, and early syphilis (per 100,000 people) all surpassed the state rates.[9] County data collected from 2012 to 2022 demonstrated that in the counties of Hampden, Worcester, and Middlesex there was an overall increase in chlamydia,

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[4] Kathryn Kost et al., *Pregnancies and Pregnancy Desires at the State Level: Estimates for 2017 and Trends Since 2012*, Guttmacher Inst. (Sept. 2021), https://data.guttmacher.org/states/table?topics=191&dataset=data&state=MA.

[5] Registry of Vital Recs. & Stats., Mass. Dep't of Pub. Health, *Massachusetts Births 2022*, at 17 (Nov. 2024), https://www.mass.gov/doc/2022-birth-report/download.

[6] *Id.* at 16, 29.

[7] *Id.* at 24, 30.

[8] Bureau of Infectious Disease & Lab'y Scis., Mass. Dep't of Pub. Health, *2023 Massachusetts Integrated HIV, STI, and Viral Hepatitis Surveillance Report* (Dec. 2024), https://www.mass.gov/doc/2020-integrated-hivaids-std-and-viralhepatitis-report/download; Bureau of Infectious Disease & Lab'y Scis., Mass. Dep't of Pub. Health, *Surveillance Data Overview of Sexually Transmitted Infections, Massachusetts, 2000-2023* (Mar. 2024), https://www.mass.gov/doc/surveillance-data-overview-of-sexually-transmitted-infections-massachusetts-2000-2023-slide-set/download.

[9] Bureau of Infectious Disease & Lab'y Scis., Mass. Dep't of Pub. Health, *Summary for Hampden County, Massachusetts, 2022* (2022), https://www.mass.gov/doc/summary- for-hampden-county-2022/download.

gonorrhea, and early syphilis.[10] Yet, while the need for reproductive health services in Western Massachusetts and the Worcester area is significant, the availability of those services there is sparse.

26. As part of its commitment to ensuring that all people have access to comprehensive reproductive health care, three of PPLM's clinics—the Greater Boston Health Center, the Central Massachusetts Health Center, and the Western Massachusetts Health Center—provide abortion services to patients who choose to terminate a pregnancy. PPLM's Western Massachusetts Health Center in Springfield and the Central Massachusetts Health Center in Worcester provide over 90% of abortion care in their regions. Without those clinics, many patients in Massachusetts would have no access to an abortion provider. As federal law requires, no federal funds under the Medicaid program are used to reimburse PPLM for the cost of providing those abortion services (except under the very limited circumstances permitted by federal law).

27. PPLM is dedicated to ensuring that every person should have equitable access to abortion—without shame, stigma, or delay—because sexual and reproductive health is essential to every person's overall health, well-being, and happiness. PPLM was one of the first health care organizations in Massachusetts to offer medication abortion through telehealth. And while abortion remains legal and protected in Massachusetts, PPLM continues to advocate for improved access to abortion, especially in regions with limited abortion providers, such as southeastern Massachusetts. In 2024, PPLM established referral partnerships with eleven public colleges to ensure students have accurate information and access to abortion services.

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[10] *Id.*; Bureau of Infectious Disease & Lab'y Scis., Mass. Dep't of Pub. Health, *Summary for Worcester County, Massachusetts, 2022* (2022), https://www.mass.gov/doc/summary-for-worcester-county-2022/download; Bureau of Infectious Disease & Lab'y Scis., Mass. Dep't of Pub. Health, *Summary for Middlesex County, Massachusetts, 2022* (2022), https://www.mass.gov/doc/summary-for-middlesex-county- 2022/download.

28. Further, PPLM contributes to expanding abortion access through our groundbreaking social science and clinical research. Added in 2016, our social science research program employs rigorous methodologies to identify and disrupt barriers to and inequities in care. For the past two decades, our clinical research arm has been steadfast in its commitment to actively pushing patient care forward and expanding access to abortion and contraception through the conduct of high-quality, award-winning clinical research that directly addresses the needs of our patients. By approaching research questions from these different perspectives and using a variety of methodologies, we have been able to broaden the impact of our research program on the field of sexual and reproductive health.

III. SERIOUS ADVERSE CONSEQUENCES OF THE DEFUND PROVISION

29. It is my understanding that PPLM is a "prohibited entity" under the Defund Provision because, among other things, PPLM received $4,744,699.47 in Medicaid payments during fiscal year 2023. Prohibiting PPLM from receiving Medicaid reimbursement will have dire consequences for PPLM and its patients.

30. In 2024, PPLM provided services to approximately 10,822 patients who were enrolled in Medicaid—nearly 35% of PPLM's patient base. In 2024, PPLM received a significant portion of its patient revenue (approximately 39%) from Medicaid reimbursements.

31. In 2024 alone, PPLM provided, through Medicaid, more than 5,237 units of contraception (including 1,255 LARCs), 242 cervical screenings, 257 breast cancer exams, and 21,463 STI tests (yielding over 500 positive results that would have otherwise gone undiagnosed).

32. It is my understanding that, as a direct result of the Defund Provision, PPLM will be prohibited from receiving federal Medicaid reimbursement for any of the health care services it provides.

33. Medicaid provides free or very low-cost health coverage for eligible families and individuals with low incomes. It is a joint federal-State program under which the federal government provides financial assistance to participating States to help them furnish care to needy persons. A State is not required to participate, but once it does, it must comply with a range of federal statutes and regulations.

34. Health care providers are not required to accept Medicaid, and many providers do not participate in the Medicaid program or strictly limit the number of Medicaid patients they will treat. For those participating health care providers, like PPLM, Medicaid works by reimbursement: specifically, the program reimburses PPLM for providing covered services to enrolled Medicaid patients. So, for example, a patient with Medicaid coverage will come to a PPLM clinic for preventive care. That patient receives birth control, an STI test, a Pap smear, or other Medicaid-covered care—likely at no cost. The PPLM clinic then submits to Medicaid a reimbursement claim for the services it provided.

35. With the Defund Provision in effect, patients are no longer able to receive health care services through the Medicaid program at PPLM clinics. On July 7 and 8 alone, 148 of PPLM's booked appointments across our health centers are for Medicaid patients. These Medicaid patients, who are close to or below the federal poverty level, are unlikely to be able to afford fees for the services they require, and PPLM clinics cannot afford to provide those services free of charge.

36. Some of PPLM's Medicaid patients who will no longer be able to obtain health care at PPLM clinics may try to find some services at Federally Qualified Health Centers ("FQHCs") or community health centers. Those safety net providers, however, generally do not specialize in reproductive health, and thus do not offer the full range of high-quality services provided by PPLM. Additionally, many FQHCs cannot offer the same immediate availability that PPLM offers.

37. Given the volume of Medicaid patients PPLM's health centers serve, even if alternative providers were theoretically available, they could not take on the dramatic influx of patients who would lose service at PPLM. In addition, as discussed above, many health care centers cap the number of Medicaid patients they see, and many private physicians see few, if any, Medicaid patients.

38. Many of PPLM's patients will therefore be unable to find another provider or will face such lengthy wait times that they will be forced to forgo services. In the greater Boston area, in particular, patients face some of the highest wait times to see a family medicine provider (an average wait time of sixty-nine days) or gynecologist (an average wait time of eighty-four days).[11] For patients waiting to see a provider, this will increase their risk of unintended pregnancy, STIs (both to themselves and their sexual partners), and undetected cancer.

39. Even those patients who can find another provider will suffer significant harm from losing access to their provider of choice, with whom they already have an established relationship. Patients covered through Medicaid choose PPLM health centers as their health care provider over other providers for numerous reasons—including PPLM's accessibility, commitment to evidence-

[11] AMN Healthcare, *2025 Survey of Physician Appointment Wait Times and Medicare and Healthcare Technology Medicaid Acceptance Rates*, http://online.flippingbook.com /view/83050962/ (last visited July 5, 2025).

based practices, use of leading-edge technology, wide range of reproductive health services and contraception options, and compassionate care. Moreover, as noted above, many patients who receive some health services elsewhere nonetheless choose PPLM for their reproductive health care because they are concerned about their privacy and fear of being judged by other providers. These essential aspects of treatment will be lost, even if a Medicaid patient can find a new provider.

40. With the Defund Provision in effect, there will be serious consequences for PPLM's ability to continue operating its health centers and provide the care our patients rely on. While we are still evaluating the full scope of the impact, early projections suggest we may need to reduce overall costs by 20–25%, which could include scaling back both health care services and staff. We may also be forced to make significant reductions to PPLM's educational and advocacy programs. These are difficult possibilities that we are expending resources to actively plan for as we assess all available options to preserve access to care.

41. While PPLM would try to preserve as many of its services and health care centers for as long as possible by reducing hours and staff, that is unlikely to provide a long-term solution. Without any access to federal Medicaid funding, within one year, we likely would have to close at least one health center. Based on current projections, PPLM currently anticipates that the Marlborough Health Center would have to close within about twelve months after losing Medicaid funds. Even then, that closure may still be insufficient to cover the revenue shortfall caused by the loss of Medicaid funds. Ultimately, even PPLM's remaining clinics would be forced to lay off additional staff and reduce operational hours, including the reduction or elimination of weekend clinic hours.

42. Closing the Marlborough Health Center would lead to almost 3,500 patients losing their reproductive health care provider of choice. Alternative providers in these areas are already

overstretched, with some having wait times of more than a week for even basic but essential services like oral birth control. The closure of PPLM clinics in these areas would overwhelm the capacity of these alternative providers, which are too small to provide services to thousands of new patients.

IV. INJUNCTION BOND

43. PPLM, a nonprofit organization, would be incapable of posting a bond in the amount of the federal funds it receives without severely curtailing its services and compromising its organizational mission. If PPLM were required to post an injunction bond, it would be foreclosed from pursuing judicial relief.

I declare under penalty of perjury that the foregoing is true and correct. Executed on July 7, 2025.

Dominique Lee

July 7, 2025
Date

EXHIBIT 3

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.; PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS; and PLANNED PARENTHOOD ASSOCIATION OF UTAH, Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; MEHMET OZ, in his official capacity as ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES; and CENTERS FOR MEDICARE & MEDICAID SERVICES, Defendants.	Case No. _____

DECLARATION OF SHIREEN GHORBANI IN SUPPORT OF PLAINTIFFS' EMERGENCY MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

I, Shireen Ghorbani, declare as follows:

1. I am the Interim President of Planned Parenthood Association of Utah (PPAU), a role in which I have served since April 2025. PPAU is an independently incorporated nonprofit organization that has provided health care services in Utah for more than fifty years. PPAU provides comprehensive sexual and reproductive health care at six health centers in the State of Utah.

2. As the Interim President of PPAU, I oversee health care operations, education and advocacy and am responsible for our organizational budget and ensuring that Utahns have access to high quality affordable health care. Through this role, I am familiar with PPAU's operations and health care services, including PPAU's patient demographics and revenue.

3. Prior to serving as the Interim President of PPAU, I served as the Chief Corporate Affairs Officer at PPAU from 2023 to 2025. Before joining PPAU, I worked as a director of community health for the largest regional health care provider in the intermountain west with a focus on reducing Utah's uninsured population. I am a former Salt Lake County Councilmember and served in the United States Peace Corps. I have a Master of Arts degree in Communication Studies from the University of Nebraska-Lincoln, and a Master of Philosophy in Organizational Communication and Policy from the University of Utah.

4. I am familiar with Section 71113 of An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14 (the "Defund Provision"). I understand that this provision prevents Planned Parenthood members around the country from receiving reimbursements for any health care services they provide to patients through the Medicaid program.

5. PPAU's patient population includes patients with low incomes who otherwise may lack access to affordable, high-quality sexual and reproductive health care, including patients who rely on Medicaid for health insurance. In 2024, PPAU provided health care services to 2,096 patients through the Medicaid program.

6. The Defund Provision will cause immediate and irreparable harm to PPAU and its patients. As discussed below, the Defund Provision forces PPAU to stop seeking Medicaid reimbursements. As a result of losing the ability to seek Medicaid reimbursement, PPAU has already started turning away patients who cannot pay for care without reimbursement from

Medicaid. Most of those patients will be unable to privately pay PPAU for our services or find affordable, high-quality sexual and reproductive health care at other providers in their area. The loss of hundreds of thousands of dollars in Medicaid revenue each year will likely force PPAU to lay off full-time staff, limit the health care services it provides, and potentially close health centers as a result.

7. I am over the age of eighteen and have personal knowledge of the matters herein or have acquired such knowledge by personally examining business records kept in the normal course of business by PPAU. If called upon to testify, I could and would testify competently to the facts in this declaration.

I. PPAU's Organization & Services

8. PPAU is a 501(c)(3) nonprofit organization organized under the laws of the State of Utah, with its principal office located in Salt Lake City, Utah. All six of PPAU's health centers are essential community providers under 45 C.F.R. § 156.235 and are primarily engaged in family planning services, reproductive health care, and related medical care.

9. PPAU is an independently organized corporation with its own chief executive officer, board of directors, bylaws, management, and staff. PPAU employs 106 staff members who handle the day-to-day operations of PPAU's health centers and educational services.

10. Founded in 1970, PPAU's mission is to empower Utahns of all ages to make informed choices about their sexual health and to ensure access for Utahns to affordable, quality sexual and reproductive health care and education. As part of that mission, PPAU established the Planned Parenthood Action Council of Utah, a separately incorporated nonprofit organization tax-exempt under section 501(c)(4) to engage in education, advocacy, and limited electoral activities, in furtherance of PPAU's mission.

11. PPAU operates six health centers located in Ogden, Orem, Salt Lake City (which has two health centers), South Jordan, and West Valley City. PPAU also offers some types of care through telehealth. PPAU provides a full range of sexual and reproductive health services, including well-person preventative care visits; breast exams; pap tests; sexually transmitted infection ("STI") testing and treatment; a wide range of U.S. Food and Drug Administration ("FDA")-approved contraception methods, including highly effective, long-acting reversible contraceptives; pregnancy testing; vaccines; risk assessments for pregnant patients to screen for high-risk issues; referral services for pregnant patients; urinary tract infection treatment; cervical cancer and testicular cancer screening; colposcopy; fertility awareness services; vasectomies; and abortions. All of PPAU's health centers generally offer same-day appointments and walk-in availability, and two of PPAU's health centers generally offer weekend and evening hours.

12. PPAU currently provides abortions at its two health centers in Salt Lake City—the Metro Health Center and Salt Lake Health Center.

13. In 2024, PPAU provided health care to nearly 30,000 patients through more than 44,000 total visits to its health centers, including 19,341 birth control pills, 2,278 implantations of intrauterine devices (IUDs), 12,303 pregnancy tests, 89 vasectomies, 1,592 pap smears, and 2,676 abortions.

14. PPAU also provides comprehensive education about sexual and reproductive health. Through its research-based educational programs, PPAU works to provide all Utahns with the accurate, reliable information they need to make responsible decisions and to stay healthy. In 2024, PPAU's educators reached 5,106 individuals throughout Salt Lake County, Utah County, and Summit County.

15. To better serve its mission, PPAU is a member of Planned Parenthood Federation of America ("PPFA"), a 501(c)(3) organization that provides support to Planned Parenthood members nationwide. PPAU pays annual dues to PPFA to maintain its membership. As a member of PPFA, PPAU receives the right to use the Planned Parenthood name and service mark and participate in programs organized by PPFA. PPAU's membership in PPFA helps PPAU serve its core mission. PPFA lends valuable advice and technical support in areas including clinical research, compliance with the medical standards and guidelines, revenue management, development, public affairs, communications, and expanding access to sexual and reproductive health care. In addition, because only providers who meet PPFA's stringent accreditation standards are permitted to use the Planned Parenthood name, patients know that they can trust Planned Parenthood members such as PPAU for expert, nonjudgmental care.

II. PPAU's Role as a Medicaid-Enrolled Provider

16. Like all other eligible Planned Parenthood members throughout the country, PPAU is a Medicaid-enrolled provider. PPAU provides health care to patients who rely on Medicaid for health insurance and seeks reimbursement from Medicaid funds for the provision of eligible health care services.

17. PPAU's patient population includes patients with low incomes who otherwise may lack access to affordable, high-quality sexual and reproductive health care, including patients who rely on Medicaid for health insurance. In 2024, 61% of the patients served by PPAU had no insurance, 6% relied on public insurance, and 32% relied on private insurance. Approximately half of PPAU's patients live at or below the federal poverty line. Four of PPAU's health centers are in communities classified by the federal government as Primary Care Health Professional

Shortage Areas ("HPSAs"). Our Utah Valley Health Center is also in a community classified as a Medically Underserved Area/Population.

18. PPAU does not limit the number of Medicaid patients it serves. Of the nearly 30,000 patients PPAU served in 2024, 2,096 were Medicaid-enrolled patients. In federal fiscal year 2023, PPAU received $706,251.02 in Medicaid reimbursements.

III. The Defund Provision Will Irreparably Harm PPAU and Its Patients

19. It is critical that PPAU be allowed to continue to seek reimbursement for health care it provides to patients through the Medicaid program. Core to PPAU's mission is its ability to serve patients with low incomes and from marginalized communities, who may otherwise lack access to affordable, high-quality sexual and reproductive health care. Providing health care to patients through the Medicaid program—which primarily serves low-income individuals and families—is a key part of PPAU's fulfillment of that mission.

20. Even though PPAU did not receive more than $800,000 in Medicaid payments in federal fiscal year 2023, which is one of the criteria listed for being a "prohibited entity" under the Defund Provision, I understand that the Defund Provision could be construed to prohibit PPAU from receiving Medicaid reimbursements due to PPAU's association with PPFA and other Planned Parenthood members. Because of this possibility, and the potential risk of liability arising therefrom, PPAU has had no choice but to stop seeking Medicaid reimbursement upon the law's enactment.

21. Because PPAU's health centers cannot afford to provide health care services free of charge, patients will no longer be able to receive health care services through the Medicaid program at PPAU's health centers if the Defund Provision is not prevented from going into effect.

PPAU has already had to turn away Medicaid patients who had appointments in its health centers on Saturday, July 5.

22. Many of PPAU's Medicaid-enrolled patients will likely be unable to find another provider of affordable, high-quality sexual and reproductive health care in their area, much less one that sees Medicaid patients. For instance, patients in Orem and Ogden have few options in their area other than PPAU's health centers for affordable, high-quality sexual and reproductive health care. Even those of PPAU's patients who can find another provider of affordable, high-quality sexual and reproductive health care may nonetheless be subject to significant wait times before receiving that care.

23. PPAU's Medicaid-enrolled patients will also be harmed by losing access to their chosen provider. Patients come to PPAU because they know they will receive affordable, high-quality sexual and reproductive health care in a safe, affirming environment without facing stigma, shame, or unnecessary barriers to care. PPAU's patients have trusting relationships with their providers, who they rely on for critical and often life-saving health care. PPAU's Medicaid-enrolled patients will be harmed if they are forced to immediately stop seeking care at their chosen health care provider and to instead search for a new provider elsewhere, or not be able to obtain care at all.

24. In addition to the harm to PPAU's patients, PPAU will also be immediately and irreparably harmed by the Defund Provision. In federal fiscal year 2023, PPAU received $706,251.02 in Medicaid reimbursements. If PPAU can no longer receive reimbursements for the health care it provides to patients through the Medicaid program, PPAU will lose hundreds of thousands of dollars of revenue on average each year. This loss in revenue will force PPAU to lay off full-time staff, limit the health care services it provides, and potentially close health centers as

a result. When the federal government began to withhold Title X disbursements from PPAU on March 31, 2025, this withholding constituted approximately $2.8 million annually (twenty percent of PPAU's overall annual revenue). As a result of this withholding, PPAU was forced to lay off eighteen full-time staff members (approximately twenty percent of PPAU's staff) and to close two health centers (approximately twenty percent of its health centers). I anticipate that PPAU will similarly have to make proportionate cuts to its health centers and staff if it cannot seek Medicaid reimbursements.

25. PPAU also recently implemented a workflow to connect uninsured patients to health insurance navigators to assist eligible patients through the process of enrolling in the Medicaid program in an attempt to serve more patients through that program. Through the implementation of this workflow, PPAU had expected to see the number of patients it serves through the Medicaid program grow, and consequently had also expected to receive more Medicaid reimbursements on average. The Defund Provision will prevent PPAU and the patients it serves from seeing the expected benefits of this workflow.

IV. Injunction Bond

26. PPAU, a nonprofit organization, would be incapable of posting a bond in the amount of the federal funds it receives without severely curtailing its services and compromising its organizational mission. If PPAU were required to post an injunction bond, it would be foreclosed from pursuing judicial relief.

I declare under penalty of perjury that the foregoing is true and correct. Executed on July 7, 2025.

Shireen Ghorbani

July 7, 2025
Date

EXHIBIT 4

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.; PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS; and PLANNED PARENTHOOD ASSOCIATION OF UTAH, Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; MEHMET OZ, in his official capacity as ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES; and CENTERS FOR MEDICARE & MEDICAID SERVICES, Defendants.	Case No.

DECLARATION OF JENNA TOSH
IN SUPPORT OF PLAINTIFFS' EMERGENCY MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

I, Jenna Tosh, PhD, declare and state as follows:

1. I am the President and CEO for Planned Parenthood California Central Coast ("PPCCC"), a Planned Parenthood Federation of America ("PPFA") member with health care centers in Santa Barbara, Ventura, and San Luis Obispo counties in California. I am also the Chair of the Board of California Planned Parenthood Education Fund ("CPPEF"), the statewide entity

that represents the seven separately incorporated, independent Planned Parenthood members providing comprehensive sexual and reproductive health care services in the State of California (collectively, the "Planned Parenthood Members").

2. This declaration is based on my personal knowledge, a review of data and studies compiled by CPPEF, a review of CPPEF's business records, and the knowledge obtained in the course of my twenty years of service at Planned Parenthood entities. Statements about the other California Planned Parenthood Members I make are based on information I have received from them in connection with my role at CPPEF. If called and sworn as a witness, I could and would testify competently to the information in this declaration.

3. I submit this declaration in support of Plaintiffs' Motion for a Temporary Restraining Order and Preliminary Injunction, which seeks to prevent the implementation of Section 71113 of An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14 ("PP Defund" or "Section 71113"), which prohibits federal Medicaid funding from being used for payments for services provided by Planned Parenthood Members' health care in California's Medicaid program ("Medi-Cal"). I am familiar with the PP Defund provision.

4. As explained more fully below, the PP Defund will have devastating consequences for Planned Parenthood Members in California and their health centers, as well as Californians who rely on them for comprehensive sexual and reproductive health and family planning care. Over 80% of patients who visit Planned Parenthood Members' health centers in California rely on Medi-Cal for access to health care. Planned Parenthood Members' health centers serve over 25,000 patients every week in California, including one in four California women of reproductive age who need publicly funded family planning services.[1]

[1] Nakeisha Blades et al., *Publicly Supported Family Planning Services in the United States, 2020:*

5. The PP Defund abruptly cuts off payments for all services Planned Parenthood Members' health centers provide to patients in Medi-Cal programs, including the State's family planning services program, the Family Planning, Access, Care, and Treatment ("Family PACT") Program, for a period of one year. This sudden loss of revenue has led to uncertainty around the continued ability of Planned Parenthood Members' health centers to serve the 25,000 patients a week that rely on them for care.

6. As a result of the PP Defund, the seven California Planned Parenthood Members anticipate they will need to close health centers, drastically cut their health centers' hours and days of operation, reduce their workforces, and scale back the services they provide. Unless a temporary restraining order is granted, the California Members will need to scale their health care services back immediately. This means every patient who relies on Planned Parenthood Members' health centers in California will have more difficulty accessing services including family planning, screening and treatment for sexually transmitted infections ("STIs"), and cancer screenings. In the Medi-Cal provider network, Californians will find it especially difficult to access sexual and reproductive health care services and education throughout the State, and patients from California and those who come from out of state will have fewer options to receive care. Every day that this continues, CPPEF's seven Planned Parenthood Members and their patients are irreparably harmed.

I. EMPLOYMENT AND EDUCATION BACKGROUND

7. I received my Bachelor of Arts in Political Science from the University of Florida, magna cum laude, in 2004. I then earned my Master's in Political Science from the University of

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Tables and Appendix Tables, Guttmacher Inst. (2025), https://www.guttmacher.org/sites/default/files/report_downloads/publicly-supported-fp-services-us-2020-tables-and-appendix-tables.pdf; Cal. Dep't of Health Care Servs., *Family Pact Program Report*, https://familypact.org/wp-content/uploads/2023/05/FPACT-Program-Report-FY19-20.pdf (last visited July 5, 2025).

Central Florida in 2008. I did my thesis on "Sex Education Policy in Florida: Strategies for Change," which earned an award for Outstanding Political Science Master's Thesis. In 2015, I earned my PhD in Public Affairs, on the Governance and Policy Research Track, from the University of Central Florida. My dissertation was titled: "State Adolescent Health Policies and their Impact on Teen Pregnancy Outcomes."

8. I began my career as a Family Case Manager for Kids Hope United then moved to Planned Parenthood of Greater Orlando, where I served as the Director of Education and Advocacy from 2006 to 2009. In 2012, I was appointed President and CEO of Planned Parenthood of Greater Orlando. I served in that capacity until becoming President and CEO of PPCCC in February 2015.

9. PPCCC is the Planned Parenthood member with health centers in Santa Barbara, Ventura, and San Luis Obispo counties. It provides approximately 64,000 patient visits annually over three counties with six health center locations.

10. As the President and CEO of PPCCC, I serve on the board of directors of CPPEF along with the CEOs of the other California members. As of July 1, 2025, I am the chair of the CPPEF Board of Directors, a position I served previously in 2017 to 2019. In my role as CPPEF's Board Chair, I work closely with the CPPEF President and CEO to help shape policy advocacy and provide support at the statewide level on behalf of the seven separately incorporated Planned Parenthood Members operating health centers in California.

II. ORGANIZATION MISSION AND STRUCTURE

11. CPPEF is a California not-for-profit organization that provides statewide policy analysis, advocacy, and legal support to its members and works alongside government agencies, coalition partners, and stakeholders on issues related to access to comprehensive sexual and reproductive health, health care operations, and equitable access to quality health care for all

Californians, especially for people who have low incomes or who are from underserved communities.

12. CPPEF's mission is to ensure that all individuals have the freedom to make reproductive decisions and, for people to make healthy decisions, they should have access to comprehensive information and services related to sexuality, reproduction, methods of contraception, fertility control, and parenthood.

13. CPPEF is a membership organization consisting of the seven California Planned Parenthood Members. Each CPPEF member is a separately incorporated, independent non-profit organization, with its own Chief Executive Officer, Board of Directors, management, and staff. Each member provides health care and educational services in a distinct geographic region throughout California. The seven members are: PPCCC, Planned Parenthood Northern California ("PPNorCal"); Planned Parenthood Mar Monte ("PPMM"); Planned Parenthood Los Angeles ("PPLA"); Planned Parenthood Pasadena and San Gabriel Valley ("PPPSGV"); Planned Parenthood Orange and San Bernardino Counties ("PPOSBC"); and Planned Parenthood Pacific Southwest ("PPPSW").

14. While CPPEF is dedicated to ensuring access to comprehensive sexual and reproductive health care services in California, CPPEF itself does not provide medical services. Medical services are provided by CPPEF's seven California members through the 114 health centers they independently operate throughout the State, collectively providing over 1.3 million patient visits each year to patients from all 58 counties in California as well as from other states.

15. CPPEF and its member Planned Parenthood organizations are also members of Planned Parenthood Federation of America, Inc. ("PPFA").

III. PLANNED PARENTHOOD IN CALIFORNIA

16. The seven California Planned Parenthood Members independently operate 114 health centers across the State, providing over 1.3 million patient visits annually. Collectively, they are among California's largest providers of sexual and reproductive health care and sexual education.

17. The seven California Planned Parenthood Members' health center locations span from the northwest corner of the State in Eureka to the southeast corner in El Centro near the U.S.-Mexico border almost 900 miles away. These health centers are intentionally located in underserved areas, near public transportation to facilitate access for patients who rely on public transit, and in other locations where there are shortages of adequate health care resources to meet patient needs. Health centers can be found in the major metropolitan areas of Los Angeles, San Diego, San Jose, San Francisco, Oakland, and Sacramento, along California's more rural Central Coast, and throughout the State's Central Valley. There are also a number of health centers in other, more rural parts of the State, such as Antelope Valley, Victorville, Ukiah, and Redding. A true and correct copy of a map showing the location of the health centers throughout the State of California is attached as Exhibit A.

18. California Planned Parenthood Members' health centers offer a range of sexual and reproductive health care services, including the provision of birth control, including emergency contraception; testing and treatment of STIs; pregnancy testing and services; breast and cervical cancer screenings; gender-affirming care; and abortion. Some also provide primary care services. Others provide behavioral health and prenatal care services. All seven California Planned Parenthood Members provide health care services in person and via telehealth.

19. Last year, California's Planned Parenthood Members' health centers provided care to roughly 700,000 individual patients, including almost 100,000 telehealth visits. The primary

services provided during those visits included: 2.6 million tests for STIs; over 500,000 visits for contraception, including emergency contraception; almost 500,000 pregnancy tests; nearly 100,000 cancer screenings; and pre-exposure prophylaxis ("PrEP") and post-exposure prophylaxis ("PEP"), two HIV-related medications, to more than 6,000 patients.

20. The services we provide are critical to the health and well-being of our patients. Our work to screen and immunize against human papillomavirus ("HPV"), and treat pre-cancerous cervical lesions undoubtedly reduces the incidence of cervical cancer for our patients, but nonetheless, we do sometimes need to make the diagnosis. For example, last month, a PPPSGV physician diagnosed two patients with cervical cancer. The first patient presented for intrauterine device ("IUD") removal had been seen in a local emergency room due to abdominal pain, where they said they could not remove the IUD because strings were not seen and treated for a presumed pelvic infection. The patient had a large cervical mass pushing into her abdomen causing significant pain. She had sought care through multiple health providers without receiving the diagnosis. The second patient had been seen regularly by PPPSGV for cervical cell abnormalities. Monitoring closely, the PPPSGV provider was able to diagnose cancerous cells at an early stage, increasing the patient's likelihood of survival greatly. Both patients had Medi-Cal, and PPPSGV was able to connect them directly to cancer doctors once the diagnoses were made.

21. Planned Parenthood Members often diagnose patients with ectopic pregnancy, a life-threatening condition, and are often able to get them the emergency treatment they need. For example, recently, one member's health center identified an ectopic pregnancy on an ultrasound at the visit and immediately referred the patient, who was seven weeks pregnant, to Los Angeles General. She had a salpingostomy (fallopian tube-sparing surgery) before the tube ruptured.

22. As another example, two months ago, a member's health center saw a patient who

was six weeks pregnant. No pregnancy was seen in the uterus on the ultrasound. The Planned Parenthood provider drew human chorionic gonadotropin ("hCG") (a pregnancy hormone) levels, and the patient was referred the next day for evaluation at the emergency department. She was able to get Methotrexate treatment (an injection to treat ectopic pregnancy) rather than surgery due to the early diagnosis.

23. In addition, all seven California Planned Parenthood Members offer education and counseling on sexual and reproductive health, reaching nearly 100,000 Californians every year.

24. Planned Parenthood Members' health centers primarily serve patients who have low incomes and rely on Medi-Cal programs to access health care services. Approximately 90% of patients who come to Planned Parenthood Members' health centers in California have incomes that are below 200% of the federal poverty line ("FPL") ($31,300 for one person in 2025)[2] and over 80% are under the age of 35. Three out of four patients identify as people of color.

25. Patients come to Planned Parenthood Members' health centers because they know they can receive high-quality, patient-centered, confidential, compassionate, and nonjudgemental care regardless of their ability to pay. California's Planned Parenthood Members have longstanding, deeply rooted relationships in the communities they serve, and work to provide culturally-appropriate care to meet the needs of California's diverse population. For example, PPNorCal came into existence in 1929, and PPPSGV in 1933. PPCCC, PPPSW, PPLA, and PPOSBC have served their communities since the 1960's.

26. Many patients also choose to receive care at Planned Parenthood Members' health

[2] U.S. Dep't of Health & Hum. Servs., Off. of the Assistant Sec'y for Plan. & Evaluation, *2025 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii)*, https://aspe.hhs.gov/sites/default/files/documents/dd73d4f00d8a819d10b2fdb70d254f7b/detailed-guidelines-2025.pdf (last visited July 5, 2025).

centers because they are often able to see a clinician, receive care and counseling (including relevant labs and other testing), and obtain medications or supplies at one location, without having to travel to a separate lab testing facility or pharmacy. This allows patients to receive sensitive medical services confidentially and efficiently, saving time, money, and resources that would be required to arrange for childcare or to take additional time off from work or school. At Planned Parenthood Members' health centers, patients can receive help with State coverage program enrollment, be tested for STIs and then receive results and treatment if necessary, receive birth control counseling, and obtain any needed services, referrals, and medications in one visit at one location. California's Planned Parenthood Members also operate several health centers that have extended hours, including weekend hours, and provide services to accommodate patients who have inflexible work schedules, childcare, or other unique scheduling challenges.

27. The seven California Planned Parenthood Members implement programs and policies to address the unique and diverse needs of the communities they serve, including survivors of trauma and assault, people with disabilities, people with physical, mental, or social challenges, migrant workers, and people who are unhoused.

28. For example, a patient with a history of significant trauma sought an IUD as a birth control method. The patient desired sedation for the insertion because of their past trauma and came to a PPOSBC health center after their regular primary care doctor refused any type of sedation. PPOSBC was able to see the patient the next day and make sure that the patient could receive the birth control method of their choice in a manner that addressed their circumstances—ensuring that the patient felt safe and supported during the medical procedure.

29. Planned Parenthood Members' health centers in the State serve many patients who speak languages other than English. Access to care with a trusted provider is crucial for these

patients, who are more likely to have lower incomes, poorer health, and experience discrimination in the health care system. All Planned Parenthood Members' health centers in California offer language access services to address the needs of California's diverse population, including multilingual staff in many of their locations to meet the specific needs of the patient population in their communities, and telephone or video access to translators in over 200 languages.

30. For example, at PPCCC, the member where I serve as the President and CEO, we have a health center that serves a large indigenous farmworker population from Mexico. Many in that community speak the indigenous language of their region. They face many challenges related to poverty and lack of access to health care. Recently, a patient came in for a pregnancy test who did not speak English or Spanish. Our interpreter working in that health center was able to speak to her in her indigenous language. During the visit, the patient reported that she had been sexually assaulted and was pregnant as a result. She was extremely scared and was not sure she would be able to come back for another visit. We were able to do rapid testing to determine whether she had acquired an STI, provided an abortion, and inserted an IUD. The patient told our clinicians that they had helped her more than anybody else, particularly since they were able to provide all these services during one visit.

IV. PLANNED PARENTHOOD'S PARTICIPATION IN THE CALIFORNIA MEDICAID PROGRAM

31. Medi-Cal covers almost 15 million Californians—over a third of the State's population. Most Medi-Cal enrollees are covered through a state contract with a managed care plan. For beneficiaries who access care through a managed care plan, sexual and reproductive health care services, including for family planning and abortion, are available both in- and out-of-network as sensitive services.[3]

[3] Medi-Cal Providers, *Client Eligibility* 19, https://mcweb.apps.prd.cammis.medi-cal.ca.gov/

32. Of those covered by Medi-Cal, 36.6% are 20 years of age and younger.[4] 34.3% of Medi-Cal enrollees are a part of the ACA expansion adult population with incomes up to 138% of the FPL between the ages of 19–64.[5] The California Department of Health Care Services ("DHCS") manages the State's Medicaid Programs and is responsible for provider enrollment, claims processing, program design, and responding to the public.

33. The Medi-Cal program provides coverage for comprehensive sexual and reproductive health services, covering all health care services required by federal law as well as many federal optional benefits that are eligible for federal matching funds. The State also provides coverage using state-only funds for certain health care services that are not eligible for federal funds, which includes abortion, and for certain populations whose care is not eligible for federal matching funds.

34. The State administers Medi-Cal, subject to federal and state regulations, and cost of care under the program is shared between California and the federal government. The federal medical assistance percentage ("FMAP") is the percentage of costs paid by the federal government to state Medicaid programs, which varies by service type and the enrollee receiving the service. California's FMAP is 50% for most services and enrollees,[6] while certain services and enrollees, including family planning services, are eligible for an FMAP of up to 90%.[7] Current budget

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assets/907504BF-B611-4569-AA2F-AD19852DC99A/clientelig.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO (last visited July 5, 2025).

[4] Cal. Dep't of Health Care Servs., *Medi-Cal Monthly Eligible Fast Facts* 9 (May 2025), https://www.dhcs.ca.gov/dataandstats/reports/Documents/Fast-Facts.pdf.

[5] *Id*. at 13.

[6] KFF, *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*, https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/ (last visited July 5, 2025); Social Security Amendments of 1965, Pub. L. No. 89-97 (1965).

[7] Social Security Amendments of 1972, Pub. L. No. 92-603 (1972), https://www.govinfo.gov/content/pkg/STATUTE-86/pdf/STATUTE-86-Pg1329.pdf.

estimates show that federal funds cover around 60% of the total Medi-Cal program expenditures.[8]

35. The Family PACT, or FPACT, Program is a comprehensive family planning services program, part of Medi-Cal, which is funded 77.5% by the federal government. FPACT provides contraceptive and family planning-related services, along with client-centered health education and counseling, at no cost to California's residents of reproductive age with low incomes. Operating since 1997, it is administered by the DHCS, Office of Family Planning (OFP), which is responsible for program policy, program monitoring, quality improvement, and program evaluation. The Family PACT Program is designed to assist individuals who have a medical necessity for family planning services, so that they can establish the timing, number, and spacing of their children, and maintain optimal reproductive health. Family PACT serves over 600,000 income-eligible people of childbearing age.[9]

36. Family PACT patients are California residents of reproductive age who have a family income at or below 200% of the FPL.[10] FPACT patients must have a medical necessity for family planning services and either have no other source of health care coverage for family planning or meet certain criteria for eligibility. Planned Parenthood Members' health centers provide approximately 70% of the health care services that are reimbursed by Family PACT in California.[11]

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[8] Cal. Dep't of Health Care Servs., *Medi-Cal May 2025 Local Assistance Estimate for Fiscal Years 2024-25 and 2025-26* (May 2025), https://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2025_May_Estimate/MAY-2025-Medi-Cal-Local-Assistance-Estimate.pdf.

[9] Cal. Dep't of Health Care Servs., *supra* note 1, at 11.

[10] Cal. Dep't of Health Care Servs., *Family Pact: An Overview*, https://familypact.org/wp-content/uploads/2024/04/Family-PACT-Program-Fact-Sheet.pdf (last visited July 5, 2025).

[11] Cal. Dep't of Health Care Servs., *Medi-Cal May 2023 Local Assistance Estimate for Fiscal Years 2022-23 and 2023-24* (May 2023), https://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2023_May_Estimate/MAY-2023-Medi-Cal-Local-Assistance-Estimate.pdf; Dep't of Health Care Access & Info., *2023 Primary Care Clinic Annual Utilization*

37. All seven of the Planned Parenthood Members offering health care services currently participate in the Medi-Cal program and are enrolled as Family PACT providers. Approximately 54% of the patients seen at Planned Parenthood Members' health centers in California are enrolled in Medi-Cal with an additional 26% enrolled in the Family PACT program. Combined, Medi-Cal and its related programs including Family PACT make up approximately 80% of Planned Parenthood's patient visits.

38. Planned Parenthood Members' health centers are reimbursed by the State of California for eligible patient care through a combination of state and federal funding. Planned Parenthood Members' health centers in California are the backbone of the Medi-Cal program's network of sexual and reproductive health care providers and collectively provide approximately $425 million of services to patients that are covered by Medi-Cal and its related programs annually.[12] Of that, around 77%, or $328 million, is paid using federal funds.[13]

39. Planned Parenthood Members' health centers also assist and support patients who are uninsured and/or need assistance navigating publicly-funded coverage options. Many people turn to Planned Parenthood Members' health centers for care because they do not have health care coverage and have few options to obtain care. Health center staff will often assist patients who may be between jobs, recently lost their job, or simply cannot afford health care, in order to help them navigate what coverage they may be eligible for and help them enroll in coverage.

40. For example, one recent PPPSGV patient discovered that their health care coverage had expired and they were due for their birth control shot the next day. PPPSGV was able to assist

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Data (November 2024), CA.gov (July 5, 2025), https://sandbox.data.ca.gov/dataset/primary-care-clinic
-annual-utilization-data/82f4dc4e-b1fb-4961-b362-6d05534f3781.

[12] Dep't of Health Care Access & Info., *supra* note 11.

[13] Cal. Dep't of Health Care Servs., *supra* note 8.

the patient by helping them enroll in Family PACT.

41. Another patient recently visited a PPNorCal's health center after losing their insurance. The patient needed help accessing prescription medication for their chronic medical conditions. A community health worker at PPNorCal was able to assist the patient with obtaining Medi-Cal coverage, and connect them with clinicians and specialists that accepted Medi-Cal. PPNorCal was able to help their patient navigate a complex health care system and gain access to critical care and services.

42. In another example, PPMM assisted a patient who was working as an agricultural worker, and who was uninsured, to enroll in the Family PACT program, and performed a preventive care visit where the clinician identified concerning findings. PPMM was able to order imaging and diagnostic testing that resulted in a cancer diagnosis. PPMM then facilitated a referral to an oncology provider and supported the patient in enrolling in additional public coverage programs to cover the costs of the treatment.

43. At PPCCC, a patient came to one of our health centers who was uninsured. She had a breast mass that she was worried about. We helped her get funding for the visit and ordered screening, which showed that she had Stage 1 breast cancer. We then helped her make an appointment with a local oncologist and did a warm hand-off, which is known to improve the chances of survival. The patient indicated she had tried to see another Ob-Gyn, but could not afford the visit.

V. EFFECT OF THE PP DEFUND ON PLANNED PARENTHOOD MEMBERS IN CALIFORNIA

44. It is my understanding that the seven separately incorporated Planned Parenthood Members in California that operate the 114 health centers throughout the State are "prohibited entit[ies]" under the PP Defund because they are all 501(c)(3) not-for-profit organizations and

essential community providers, which operate community clinics that primarily engage in family planning and reproductive health, provide abortion, and because each received more than $800,000 in total state and federal Medicaid funding in fiscal year 2023. The PP Defund is in effect. Because Planned Parenthood members in California are now prohibited from receiving federal Medicaid payments, they are unable to submit the vast majority of claims to Medi-Cal as of the time of President Trump's signature on July 4, 2025.

45. If California Planned Parenthood Members remain unable to seek reimbursement for the vast majority of services provided to the more than 25,000 patients their health centers serve every week, they will be forced to close health centers and reduce hours, staff, and services, and Californians will lose vital access to sexual and reproductive health care. Absent a temporary restraining order and preliminary injunction, the California Planned Parenthood Members will have to scale back the health services they offer almost immediately. The PP Defund will not only impact abortion access, but will be devastating for access to family planning and other sexual and reproductive health care, not just for Medi-Cal beneficiaries but for all patients who seek care at Planned Parenthood Members' health centers in California. The PP Defund also threatens access to Planned Parenthood Members' community-based educational services that reach almost 100,000 Californians a year.

46. Even short disruptions in revenue will have drastic impacts to funding because over 80% of Planned Parenthood Members' services in California are provided to Medi-Cal and Family PACT patients. Without reimbursement for those services, California's Planned Parenthood Members will lose approximately two-thirds of their revenue, and health centers will need to close, which is a time-consuming, administratively burdensome, and expensive process. Additionally, this process will likely include termination of leases or selling health center buildings that

Members own. Once a location is closed, it sometimes never reopens. Even if funding resumes and re-opening is possible, it is very difficult, time-consuming and expensive to reopen. New staff would have to be hired and trained, new locations would have to be found to lease, new systems for medical records and billing would have to be installed and implemented, and a multitude of new licenses would have to be obtained. Plus, each Member would need to extensively expand philanthropic fundraising to raise the costs of opening health centers: expenses for insurance, billing and medical record systems, leases and staff will be incurred long before any revenues exist from services provided that could be used to cover those costs. It also takes 6 months, and perhaps longer, to get the licenses and regulatory approvals from the various State agencies to open a health center, and all of that would have to occur before a clinic could open and begin to see patients.

47. Closures of Planned Parenthood health centers will reduce the number of family planning and abortion providers in the Medi-Cal program, leading to longer wait times and more barriers to care. Californians may need to travel significant distances to receive in-person care, which is especially problematic for rural and remote areas of the state where transportation is already a significant barrier to care. For many people who live in California's vast state, patients would have to drive multiple hours for over 200 miles to access the next closest reproductive health clinic. Forcing people to travel long distances to access care results in delays in time-sensitive care, or in care becoming inaccessible.

48. In addition to the impacts on the provision of health care, the PP Defund will have huge economic consequences on the employees who work for the California Planned Parenthood Members and the communities in which their health centers are located. The seven California Planned Parenthood Members employ over 3,000 Californians, including experienced clinicians, support staff, educators, and administrative staff. Planned Parenthood's California Members will

be forced to do large lay-offs, and would need to provide severance, health care coverage for the severance period, and career transition and outplacement services for any staff laid off. The extreme and sudden nature of the PP Defund will make it difficult to adequately prepare for staff transitions and cover the costs of these transition services.

VI. PROVISION OF FAMILY PLANNING AND FAMILY PLANNING-RELATED CARE IN CALIFORNIA

49. Publicly funded family planning clinics, including Planned Parenthood Member health centers, provide essential health care to patients with low incomes, including access to contraception and other family planning services.[14] In 2020, over 2.2 million California women aged 13–44 were in need of publicly funded family planning services.[15] It is critical that providers like Planned Parenthood Members' health centers be able to continue operating; people that have trouble accessing family planning services are more likely to experience an unplanned pregnancy, contract an STI, or suffer other health complications.[16]

50. In California, Planned Parenthood Members' health centers see approximately half of all patients served at a publicly funded clinic for family planning services. Planned Parenthood Members' health centers saw half of the 1.2 million contraceptive clients served by all safety-net family planning centers in 2020 across California.[17]

51. Screening and treatment of STIs is the most cost-effective strategy for reducing adverse reproductive health outcomes, such as pelvic inflammatory disease and infertility, and

[14] Usha Ranji et al., *Financing Family Planning Services for Low-income Women: The Role of Public Programs*, KFF (Oct. 25, 2019), https://www.kff.org/womens-health-policy/issue-brief/financing-family-planning-services-for-low-income-women-the-role-of-public-programs/.
[15] Blades et al., *supra* note 1.
[16] Inst. of Med. of the Nat'l Acads., *Overview of Family Planning in the United States*, *in* A Review of the HHS Family Planning Program: Mission, Management, and Measurement of Results (2009).
[17] Guttmacher Inst., *Federally Qualified Health Centers Could Not Readily Replace Planned Parenthood* (June 4, 2025), https://www.guttmacher.org/news-release/2025/federally-qualified-health-centers-could-not-readily-replace-planned-parenthood.

their associated costs.[18] For many patients, Planned Parenthood Members' health centers are the only health care provider and trusted source for information and services related to STI testing and treatment. Over the past five years, the California Planned Parenthood Members have partnered with state and local public health officials to address the STI epidemic by increasing testing and treatment rates within their communities. In the past year, Planned Parenthood Members' health centers in California have performed over 2.6 million STI tests. Many have implemented rapid testing, which expands testing capacity and enables STI testing and treatment on the same day.

52. In 2020, only 56% of federally qualified health center (FQHC) sites nationwide reported offering contraceptive care to at least 10 women per year.[19] If Planned Parenthood Members are forced to reduce services and hours and close health center locations as a result of the PP Defund, patients will need to identify other publicly funded providers, such as FQHCs, to provide their care. FQHCs, however, are already struggling to meet a rapidly increasing demand for services and will be unable to absorb the patients of Planned Parenthood's Members in California. The California Primary Care Association ("CPCA"), which represents the community clinics in California, has stated that these clinics do not have the capacity to take on the patient volume served by Planned Parenthood Members. CPCA states: "[e]liminating Planned Parenthood from our state's comprehensive network of care would put untenable stress on remaining health centers. We do not have the capacity for such an increase in care and building such capacity would require significant capital investment." A true and correct copy of the CPCA letter dated June 3, 2025, is attached as Exhibit B.

53. For example, PPPSGV has referral relationships with local clinics that have very

[18] *See, e.g.,* Andrea K. Kennedy et al., *Direct and Indirect Cost Savings from STI Testing, Treatment, and Counseling among Foster Youth*, 49 Sexually Transmitted Diseases 86 (2022).
[19] Guttmacher Inst., *supra* note 17.

limited capacity to provide family planning services. In fulfilling this role, PPPSGV's health centers play a critical part in the safety net infrastructure. In addition to providing health care services, PPPSGV has served as a pillar within its community by providing information, education, and outreach to combat disinformation and acted as a hub for vaccine distribution to the most vulnerable.

54. In another example, PPCCC is the only safety-net, comprehensive reproductive health care provider in the State's Santa Barbara, San Luis Obispo, and Ventura counties located in the central coast region of California. Local hospitals and clinics routinely refer patients to PPCCC, especially for abortion, gynecological cancer prevention, and gender-affirming hormone therapy. Currently, the FQHCs refer their patients to PPCCC because the clinics either do not offer the range of services PPCCC provides or because they have a much longer wait time.

55. In fact, Planned Parenthood Members' health centers are much more likely than other clinic types to provide patient-centered options for care, including offering the full range of reversible contraceptive methods, providing same-day care for IUD and implant insertions, on-site dispensing of oral contraceptives, and the provision of contraceptives using telehealth.[20] Compared to other clinic types, Planned Parenthood Members' health centers offer a wider range of contraceptive methods that help patients identify and obtain methods that work best for them.

56. For example, one patient sought care at PPLA after being told by a gynecologist that it would be 5 months before they could schedule an appointment for a contraceptive implant. PPLA was able to offer the patient a same-day appointment.

57. As another example, another patient described how PPPSW staff took the time to

[20] Alicia VandeVusse et al., *Publicly Supported Family Planning Clinics in 2022–2023: Trends in Service Delivery Practices and Protocols*, Guttmacher Inst. (Nov. 2024), https://www.guttmacher.org/report/publicly-supported-family-planning-clinics-2022-2023.

talk to them about all the birth control options so they could consider what would be the best for them. They were able to make a choice about their preferred birth control method feeling equipped with the information they needed to make that decision. As the patient stated, "I'm so grateful that I was able to access care at Planned Parenthood through Medi-Cal—to get tested, get my annual exams, access birth control, and the information I needed to decide what's best for my body."

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58. In sum, it is my belief that the PP Defund will have a large and devastating impact on Planned Parenthood Members' health centers in California, widen disparities in health care, and threaten access to family planning and abortion services for Californians.

I declare under penalty of perjury that the foregoing is correct and that this declaration is executed on 6th day of July, 2025, in Santa Barbara, California.

Jenna Tosh _____ 7/6/2025

Jenna Tosh Date

Exhibit A

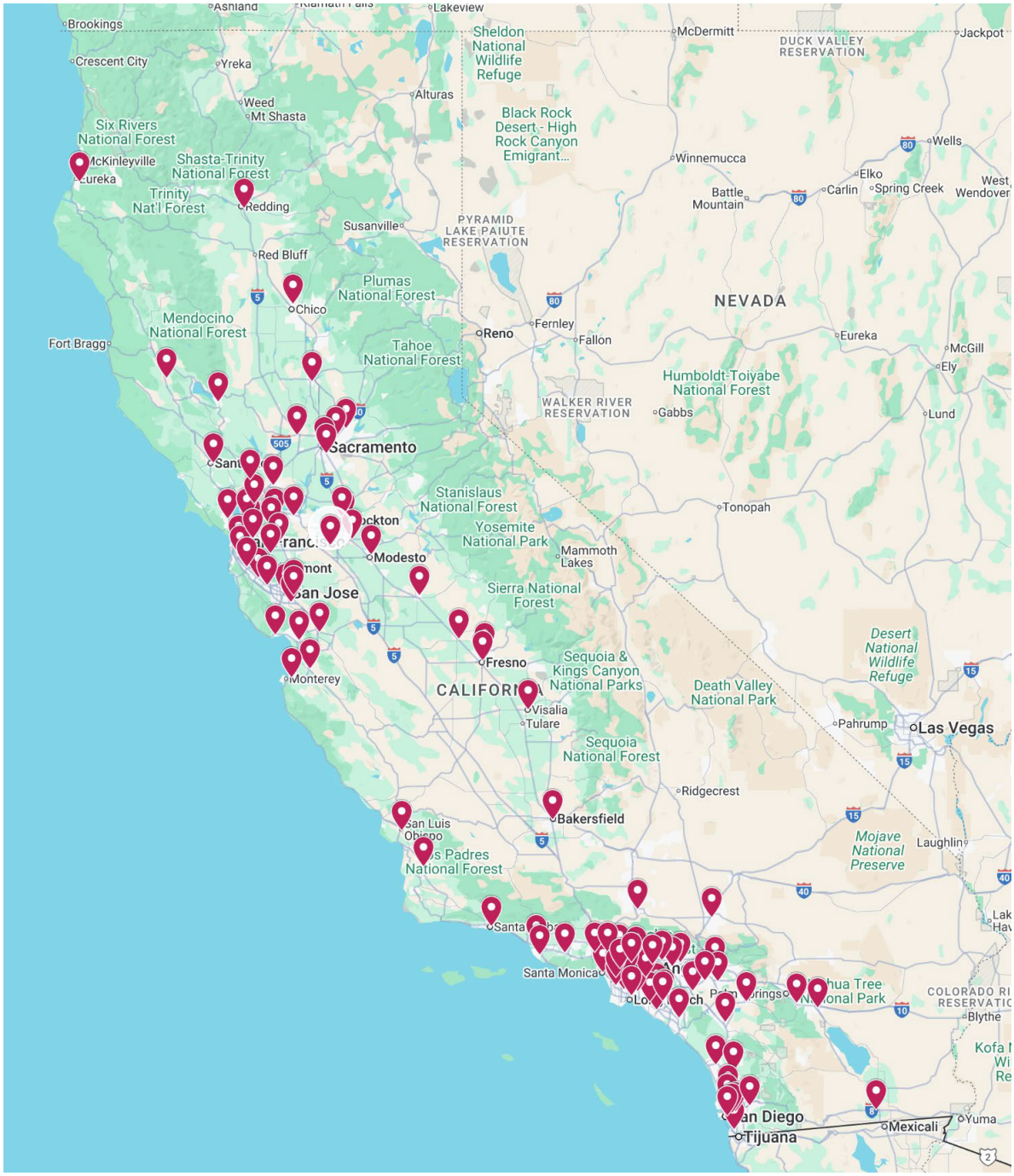
Ashland
Lakeview
Brookings
Sheldon National Wildlife Refuge
McDermitt
DUCK VALLEY RESERVATION
Jackpot
Crescent City
Yreka
Alturas
Weed
Mt Shasta
Six Rivers National Forest
Black Rock Desert - High Rock Canyon Emigrant...
McKinleyville
Eureka
Shasta-Trinity National Forest
Trinity Nat'l Forest
Redding
Winnemucca
Wells
Elko
Carlin
Spring Creek
Battle Mountain
West Wendover
Susanville
PYRAMID LAKE PAIUTE RESERVATION
Red Bluff
Plumas National Forest
Chico
NEVADA
Mendocino National Forest
Fort Bragg
Reno
Fernley
Fallon
Eureka
McGill
Ely
Tahoe National Forest
Humboldt-Toiyabe National Forest
WALKER RIVER RESERVATION
Gabbs
Lund
Sacramento
Stanislaus National Forest
Tonopah
Yosemite National Park
Modesto
Mammoth Lakes
San Jose
Sierra National Forest
Fresno
Monterey
Sequoia & Kings Canyon National Parks
Desert National Wildlife Refuge
Visalia
Tulare
Death Valley National Park
Pahrump
Las Vegas
Sequoia National Forest
Ridgecrest
Bakersfield
Mojave National Preserve
Laughlin
Santa Monica
Blythe
COLORADO RIVER RESERVATION
San Diego
Tijuana
Mexicali
Yuma

Exhibit B

California Primary Care ASSOCIATION

June 3, 2025

The Honorable Alex Padilla
The Honorable Adam Schiff
United States Senate
331 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Padilla and Senator Schiff,

The California Primary Care Association is aware of provisions in the House-passed Budget Reconciliation Bill that is currently before the Senate that would prohibit federal funding from being used for services provided by Planned Parenthood. In California, this would mean that Medi-Cal patients would lose an important point of access for family planning services, shifting care to federally qualified health centers that will be unable to meet patient needs. This provision has no purpose other than putting a moratorium on Planned Parenthood as a health care provider for ten years and in fact, according to the Congressional Budget Office, will increase the deficit by $300 million.

As the state-wide representatives of community clinics and health centers in California, who annually serve over 7.7 million Medi-Cal patients, we believe this action would negatively impact the health of our community.

Planned Parenthood currently operates 115 health centers in California and serves almost a million patients through 1.3 million total visits annually. Eliminating Planned Parenthood from our state's comprehensive network of care would put untenable stress on remaining health centers. We do not have the capacity for such an increase in care and building such capacity would require significant capital investment.

Moreover, the effort to defund Planned Parenthood would eliminate a patient's ability to choose the provider with which they feel most comfortable. Many patients rely on Planned Parenthood because they know that it is a place where they can get high quality care that is confidential and without judgment. Their reputation as a leading provider of sexual and reproductive health care means that they are the provider of choice to almost a million Californians who seek out a variety of services that include wellness exams, birth control, sexually transmitted infection (STI) testing and treatment, cancer screenings, and other preventive care. In 2024 alone, the Planned Parenthood affiliate health centers in CA conducted over 2.5 million STI tests.

Planned Parenthood is a vital component of the health care system in California and for that reason, we are opposed to any provisions in the budget reconciliation bill that will diminish their capacity to provide care in our state.

Sincerely,

Francisco J. Silva, Esq.
President and CEO
California Primary Care Association

EXHIBIT 5

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.; PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS; and PLANNED PARENTHOOD ASSOCIATION OF UTAH, Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; MEHMET OZ, in his official capacity as ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES; and CENTERS FOR MEDICARE & MEDICAID SERVICES, Defendants.	Case No. _____

EXPERT DECLARATION OF CLAIRE D. BRINDIS
IN SUPPORT OF PLAINTIFFS' EMERGENCY MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

I, Claire D. Brindis, declare that if called as a witness, I would testify competently to the following:

1. I am a Distinguished Professor Emerita (on recall) in the Department of Pediatrics and the Department of Obstetrics, Gynecology and Reproductive Health Sciences at the University of California, San Francisco ("UCSF"), where I have held positions as a researcher and faculty member since 1982.

2. I am Emerita Director of the Philip R. Lee Institute for Health Policy Studies. This Institute is an interdisciplinary health policy research unit that collaborates with universities, the private sector, government, and community-based organizations to address issues concerning health care delivery, access and quality of care, and health services outcomes. I have been associated with this Institute since 1983 and was its Director from 2008 to 2020.

3. I am a Founding Director and currently Senior Advisor of the UCSF Bixby Center for Global Reproductive Health. This Center leads research and training programs around the world to improve reproductive health policies, treatment, and care guidelines around the world. I have been associated with this Center since its founding in 2004.

4. I received a Master's Degree in Public Health in Maternal and Child Health, International Health, and Family Planning from the University of California at Los Angeles and a Doctoral Degree in Public Health (with a specialty in Behavioral Sciences) from the University of California at Berkeley.

5. A copy of my curriculum vitae is attached as Exhibit A.

6. My area of academic expertise is child, adolescent, and women's health policy. I have conducted research regarding reproductive health services for men and women, pregnancy and pregnancy prevention, and health care reform, among other topics. Of particular relevance, I

served on the 2011 Institute of Medicine Women's Committee on Preventive Services for Women, which produced a report of recommendations for women's health, including an annual preventive health visit, counseling on sexually transmitted infections ("STIs"), and access to all Food and Drug Administration ("FDA")-approved contraceptive services without copayment. I also served for nearly 20 years as the co-Principal Investigator for California's Family Planning, Access, Care, and Treatment ("PACT") Program, the state's Medicaid waiver program for providing family planning services to low-income men and women and one of the largest publicly funded family planning programs in the country. I have served as the Principal Investigator for a National Institutes of Health-funded program, Building Interdisciplinary Research Careers in Women's Heath, which supports junior faculty conducting research aimed at improving women's health.

7. I have served as a research grantee, advisor, and/or consultant to a variety of federal government projects and agencies since 1983, including: member of the advisory panel for the U.S. Congress Office of Technology Assessment on Adolescent Health (1991); advisor to the Centers for Disease Control and Prevention ("CDC") regarding adolescent pregnancy prevention efforts (1995-2000); member of the Adolescent Health Work Group, Maternal and Child Health Bureau, U.S. Department of Health and Human Services ("DHHS") (1995-1996); member of the Steering Committee, Women's Health Panel, Bright Futures for Women's Health and Well-Being: National Guidelines Project, Maternal and Child Health Bureau, DHHS (2001-2002); member of the Technical Experts Advisory Committee for the Office of Population Affairs, Office of Family Planning, and CDC in connection with revision of the Title X Family Planning Program Guidelines, Adolescent Panel (2011); member for the DHHS and Health Resources and Services Administration ("HRSA") Office of Women's Health Expert Panel on Curriculum Development in Women's Health (2012); expert panel member for the DHHS and the Office of Adolescent

Health (OAH) "Think Adolescent Health" agenda (2013); member of DHHS and OAH's Technical Workgroup on the Cost Study of Evidence-Based Teen Pregnancy Prevention Programs (2013); technical expert panel member for CDC panel on The National Survey of Children's Health (2015); member of the CDC's Adolescent Reproductive Health Clinical Program Improvements Workgroup (2018-2019); and special emphasis panel member of the CDC's Developing and Evaluating Adolescent, Parent, and Provider Resources to Improve Adolescent Use of Sexual Health Services panel (2020).

8. I have not been paid a fee for my work in connection with this case. I will be reimbursed for all reasonable and necessary out-of-pocket expenses incurred in connection with this engagement, such as travel expenses. This reimbursement is not contingent on the nature of my findings or conclusions, or on the outcome of this litigation.

9. I have been asked to provide my opinion on the effect on public health outcomes of Section 71113 of An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14 ("Section 71113"), which I understand is intended to prohibit Planned Parenthood Federation of America ("PPFA") Member organizations from receiving federal funds through Medicaid.

10. In this declaration, I use shorthand to discuss PPFA Members' health centers, using the terms "Planned Parenthood," "Planned Parenthood health centers," and "Planned Parenthood clinics." For purposes of this declaration, unless otherwise indicated, those terms refer to the health centers owned and operated by PPFA Members, all of which include the words "Planned Parenthood" in their names.

11. As further explained below, restricting Planned Parenthood's ability to provide essential health care services jeopardizes the health of patients and risks serious adverse public health outcomes—in particular, an increase in unintended pregnancies and attendant

complications, and an increase in undiagnosed and therefore untreated sexually transmitted infections. Because many patients rely on publicly funded healthcare services, the resulting increase in covered births, complications, and STIs will mean Section 71113 will lead to a net *increase* in public spending.

12. I begin by providing an overview of Planned Parenthood's role in the system of providing reproductive health care to safety-net patients, *i.e.*, patients who receive such services through publicly funded health care programs. I then explain that if Planned Parenthood Members are excluded from receiving federal funds in the form of Medicaid reimbursement for the health care services they provide, alternative providers will not be able to fill the gaps in services that would result. I further explain below that serious public health consequences will result from Section 71113's exclusion of Planned Parenthood from the safety-net of health care providers that provide federally funded health care services under Medicaid and the lack of alternative providers who can offer similar services.

I. PLANNED PARENTHOOD MEMBERS' CENTRAL ROLE IN PROVIDING REPRODUCTIVE HEALTH CARE

A. Background Information on Medicaid

13. Below, I provide a brief description of Medicaid and explain Planned Parenthood's important role in providing health care to patients under those programs.

14. Millions of Americans rely on publicly funded programs, such as Medicaid, for all or a portion of their health care needs. Medicaid is a joint federal and state program that, together with the Children's Health Insurance Program ("CHIP"), provides health coverage to over 78

million Americans, including children, pregnant women, parents, seniors, and individuals with disabilities.[1] Medicaid is the single largest source of health coverage in the United States.[2]

15. States are not required to participate in the Medicaid program, but all states and the District of Columbia currently participate.[3] The federal share of Medicaid funding varies from state to state, but in every state, the majority of funding for the program is provided by the federal government.

16. Medicaid was initially enacted as a safety-net health coverage program for individuals with low incomes, with a particular emphasis on dependent children and their mothers, individuals with disabilities, and the elderly.[4] When a state chooses to participate in the Medicaid program, federal law requires states to cover certain groups of individuals. Low-income families, qualified children and pregnant women, and individuals receiving Supplemental Security Income are examples of mandatory eligibility groups.[5]

17. The Affordable Care Act of 2010 created the opportunity for states to expand Medicaid to cover nearly all low-income Americans under age 65. In particular, states have the

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1 *Eligibility Policy*, https://www.medicaid.gov/medicaid/eligibility-policy (last visited July 1, 2025).

2 *Id.*

3 Alison Mitchell et al., Cong. Rsch. Serv., R43357, Medicaid: An Overview (2025), https://www.congress.gov/crs-product/R43357.

4 *Program History and Prior Initiatives*, Medicaid, https://www.medicaid.gov/about-us/program-history (last visited July 3, 2025); *Why did they do it that way? Eligibility policy*, National Association of Medicaid Directors, (Nov. 13, 2023), https://medicaiddirectors.org/resource/why-did-they-do-it-that-way-eligibility-policy (last visited July 3, 2025).

5 *See List of Medicaid Eligibility Groups, Mandatory Categorically Needy*, Medicaid, https://www.medicaid.gov/medicaid/eligibility/downloads/list-of-eligibility-groups.pdf (last visited July 1, 2025).

option to extend eligibility to adults with incomes at or below 133% of the federal poverty level.[6] Forty-one states, including Massachusetts, Ohio, and Maryland, as well as the District of Columbia, chose to expand coverage to adults.[7] Ten states have not done so.[8] Nearly 40% of adult women of reproductive age who are enrolled in Medicaid are covered through the expansion pathway.[9]

18. Medicaid is an entitlement program; if a patient is entitled to receive benefits under the program's criteria, then the patient may enroll and receive health care services from Medicaid providers.

19. As relevant to this case, Medicaid reimburses health care providers for covered services that they have delivered to eligible patients. Many health care providers do not participate in Medicaid because reimbursement rates are often considered low and thus less financially viable.[10] States have the option to require cost-sharing (such as deductibles and copays) from beneficiaries, but those cost-sharing requirements are generally nominal, and under federal law they cannot be imposed for family planning services.[11]

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6 Eligibility Policy, *supra* note 1.

7 *Status of State Action on the Medicaid Expansion Decisions*, Kaiser Family Foundation (May 9, 2025), https://www.kff.org/status-of-state-medicaid-expansion-decisions/.

8 *Id.*

9 *5 Key Facts About Medicaid and Family Planning*, Kaiser Family Foundation (May 29, 2025), https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-and-family-planning/.

10 *See, e.g.*, *Evaluating the Effects of Medicaid Payment Changes on Access to Physician Services*, Medicaid and CHIP Payment and Access Commission, 1 (Jan. 2025), https://www.macpac.gov/wp-content/uploads/2025/01/Evaluating-the-Effects-of-Medicaid-Payment-Changes-on-Access-to-Physician-Services.pdf.

11 *See* 42 CFR 447.56(a)(2)(ii) ("The agency may not impose cost sharing for … family planning services and supplies.").

20. There are several types of providers, including Planned Parenthood Members, that use Medicaid and other sources of federal funding to provide health care services to safety-net patients.[12] For example, community health centers ("CHCs") and federally qualified health centers ("FQHCs") provide health care services to low-income individuals in medically underserved or areas where there is a health professional shortage.[13] Unlike Planned Parenthood, those providers usually do not specialize in family planning; rather, they may provide, among others, primary care, dental care, and/or mental health services.

B. Planned Parenthood Members' Crucial Public Health Role in Providing Publicly Funded Health Care

21. Planned Parenthood plays a central role in the national fabric of federally-funded health care providers. In 2023, Planned Parenthood health centers served over two million patients, collectively delivering around 9.5 million services.[14] In 2022, 53% of Planned

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[12] Title X is a federally-funded health care program dedicated to providing primarily low-income individuals with comprehensive family planning and related preventive health services. Unlike Medicaid reimbursement, Title X grantees receive finite grant awards.

[13] For the purposes of this report, the majority of my opinions are focused on FQHCs, rather than public health clinics, hospital outpatient clinics, or other facilities where patients may seek health care services. Though all these facilities are integral to the health care provider network, this report compares the services and impact of Planned Parenthood health centers with those of FQHCs based on available data and because these providers primarily serve similar populations of patients.

[14] Planned Parenthood Federation of America, *A Force for Hope*, *Planned Parenthood Annual Report 2023-2024*, at 23 (2023-2024), https://www.plannedparenthood.org/uploads/filer_public/ec/6d/ec6da0d6-98e5-4278-8d11-99a5cba8e615/2024-ppfa-annualreport-c3-digital.pdf.

Parenthood patients relied on Medicaid and other government-funded health care programs to pay for their care.[15]

1. Planned Parenthood Health Clinics Serve a Critical Mass of Patients Seeking Family Planning Services

22. Planned Parenthood health centers are critical both in terms of the types of services they provide and the population they serve. The volume and breadth of Planned Parenthood health centers' provision of contraceptive services sets them apart from other safety-net providers. Among health care providers who accept Medicaid, Planned Parenthood Members serve contraceptive-seeking patients in numbers that are disproportionate to their collective size.[16] The Guttmacher Institute, a sexual and reproductive health-focused research and policy organization, estimated that in 2020, Planned Parenthood health centers comprised just 6% of publicly funded clinics providing contraceptive services, but 33% (1.6 million) of all female contraceptive clients

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[15] It is my understanding that the other 47% of Planned Parenthood patients pay for care out of pocket or through private insurance based on Planned Parenthood's sliding fee scale. *See Planned Parenthood patients rely on the Title X family planning program for health care*, Planned Parenthood Federation of America (Mar. 12, 2025), https://www.plannedparenthood.org/about-us/newsroom/press-releases/planned-parenthood-patients-rely-on-the-title-x-family-planning-program-for-health-care (last visited July 3, 2025); *see also Rightfully Ours*, Planned Parenthood Federation of America, https://www.plannedparenthoodaction.org/rightfully-ours/for-planned-parenthood#:~:text=In%202023%2C%20there%20were%20more,to%20pay%20for%20their%20care (last visited July 1, 2025).

[16] The majority of Medicaid beneficiaries ages 15-49 who receive family planning services at a Planned Parenthood clinic received contraceptive and STI services. *The Impact of Medicaid and Title X on Planned Parenthood*, Kaiser Family Foundation (updated April 30, 2025), https://www.kff.org/medicaid/issue-brief/the-impact-of-medicaid-and-title-x-on-planned-parenthood/.

(4.7 million) who visited a publicly funded clinic visited a Planned Parenthood health center.[17] Moreover, according to a newly released health tracking poll, one in three women state that they have gone to a Planned Parenthood clinic for care, as well as one in ten men, and nearly half of Black women.[18] In 2020, each Planned Parenthood clinic served on average 2,640 female contraceptive patients, compared with 330 female contraceptive patients served on average at an FQHC, 320 served at a health department, and 410 served at a hospital.[19] In 2021, 11% of all female Medicaid beneficiaries ages 15-49 who received family planning services went to a Planned Parenthood health center.[20] A study of publicly funded clinics providing family planning services found that in 2022-2023, 47% of Planned Parenthood health centers cared for at least 50 contraceptive patients each week, compared with only 6% of health department sites and 25% of FQHCs that serve the same volume of clients.[21]

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[17] In comparison, public health departments accounted for 20% of publicly funded clinics and served 13% of all contraceptive clients in 2020. FQHCs administered 58% of clinics and served 38% of clients. Hospital outpatient sites accounted for 7% of clinics and served 9% of clients. Other independent clinics represented 9% of total clinics and served 7% of clients. Jennifer J. Frost et al., *Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Use, 2020,* Guttmacher Inst., 8, App. Table 7 (May 2025), https: //www.guttmacher.org/report/publicly-supported-FP-services-US-2020; *see also Federally Qualified Health Centers Could Not Readily Replace Planned Parenthood*, Guttmacher Inst. (May 13, 2025) https://www.guttmacher.org/news-release/2025/federally-qualified-health-centers-could-not-readily-replace-planned-parenthood.

[18] Brittni Frederiksen et al., *Major Federal and State Funding Cuts Facing Planned Parenthood*, Kaiser Family Foundation (May 15, 2025), https://www.kff.org/womens-health-policy/issue-brief/major-federal-and-state-funding-cuts-facing-planned-parenthood/.

[19] *Federally Qualified Health Centers Could Not Readily Replace Planned Parenthood*, Guttmacher Inst. (May 13, 2025) https://www.guttmacher.org/news-release/2025/federally-qualified-health-centers-could-not-readily-replace-planned-parenthood.

[20] *The Impact of Medicaid and Title X on Planned Parenthood*, *supra* note 16.

[21] Alicia VandeVusse et al., *Publicly Supported Family Planning Clinics in 2022-2023: Trends in Service Delivery Practices and Protocols*, Guttmacher Inst., 13, App. Table 1 (2024), https://www.guttmacher.org/sites/default/files/report_pdf/publicly-supported-family-planning-clinics-2022-2023.pdf.

23. Planned Parenthood Members are well regarded for providing high quality, culturally competent care, and patients often choose to seek care at Planned Parenthood health centers over other health care providers.[22] Studies confirm that "Planned Parenthood clinics have shown a higher quality of care for family planning services compared with other provider types."[23] Planned Parenthood health centers are also more likely than all other types of publicly funded clinics to institute written counseling protocols for health screenings like intimate partner violence and substance abuse.[24]

24. For example, a 2021 study of women seeking services at Planned Parenthood health centers found that nearly 60% of surveyed participants chose Planned Parenthood over other health care centers because they "want[ed] to support [Planned Parenthood] health centers."[25] Patients reported that Planned Parenthood clinics had increased appointment availability compared to other clinics, were easy to get to, and that staff understood their needs. Notably, patients also frequently identified that they could get services at Planned Parenthood clinics in a confidential manner that they could not receive at other clinics.[26]

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22 *See* Anna Newton-Levinson et al., *Influences on Women's Care Seeking at Planned Parenthood Health Centers in Two Southern States*, 31-5 Women's Health Issues 485 (2021), [doi: 10.1016/j.whi.2021.03.003].

23 Marion W. Carter et al., *Referral Practices Among U.S. Publicly Funded Health Centers that Offer Family Planning Services*, 27 Jour. Women's Health 994 (Aug. 2018), [doi: 10.1089/jwh.2017.6487].

24 Marion W. Carter et al., *Four Aspects of the Scope and Quality of Family Planning Services in US Publicly Funded Health Centers: Results from a Survey of Health Center Administrators*, 94 Contraception 340, 342-343, Table 4 (2016), [doi: 10.1016/j.contraception.2016.04.009].

25 Newton-Levinson et al., *supra* note 22, at 489.

26 *Id.* at 490.

25. Relative to FQHCs, Planned Parenthood health centers are also likely to have staff trained to address the special needs of certain groups of clients.[27] Specifically, Planned Parenthood health centers had training to work with adolescents (91% of Planned Parenthood facilities to 72% of FQHCs); lesbian or gay individuals (83% to 46%); individuals experiencing intimate partner violence (81% to 68%); non-English-speaking individuals (82% to 65%); and men (77% to 59%).[28] A provider's cultural competence is particularly important for underrepresented groups. For example, in a study of Latino adolescents, the authors expressed that optimal pregnancy-prevention programs caring for Latino youth should include the following: having culturally sensitive and nonjudgmental staff, being responsive to Latino subgroup differences, emphasizing education, and recognizing cultural values regarding gender roles.[29]

2. Planned Parenthood Members Readily Provide A Full Range of Accepted Contraceptive Services

26. Planned Parenthood health centers are often the only reproductive health care provider available to patients seeking publicly funded services. Moreover, in 238 of the 415 counties where Planned Parenthood health centers were located in 2015, Planned Parenthood health centers served at least half of the women obtaining publicly supported contraceptive

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[27] Jennifer J. Frost et al., *Variation in Service Delivery Practices Among Clinics Providing Publicly Funded Family Planning Services in 2010*, Guttmacher Inst., 12 (2012), https://www.guttmacher.org/sites/default/files/report_pdf/clinic-survey-2010.pdf. Although this study is from 2012, it is my opinion that the findings from this study, as well as others cited in this report, reflect current program information about family planning clinics and the services they provide.

[28] *Id.* at 22, 38, Table 9.

[29] Anne K. Driscoll et al., *In Their Own Words: Pregnancy Prevention Needs of Latino Teen Mothers*, 1 Cal. Journal of Health Promotion 118, 120 (2003).

services from a safety-net health center.[30] In 38 of the 415 counties where Planned Parenthood health centers were located in 2015, Planned Parenthood was the only safety-net family planning center in that county.[31] As of 2017, almost two-thirds (64%) of the 20 million women in need of publicly funded contraceptive care lived in counties with a Planned Parenthood health center.[32] Moreover, 24% of those women lived in counties where a Planned Parenthood Member serves the majority of those obtaining publicly supported contraceptive care from safety-net providers.[33]

27. In addition to providing contraceptive care to a large number of patients, Planned Parenthood Members provide a broader range of contraceptive methods relative to other providers.[34] Planned Parenthood clinics are much more likely than other publicly funded clinics providing family planning services to have met the CDC's objective to provide the full range of U.S. Food and Drug Administration ("FDA")-approved methods of contraception (94% of Planned

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30 Kinsey Hasstedt, *Understanding Planned Parenthood's Critical Role in the Nation's Family Planning Safety Net*, 20 Guttmacher Pol'y Rev. 12, 14 (2017), https://www.guttmacher.org/sites/default/files/article_files/gpr2001216.pdf.

31 *Id.*

32 Memorandum from Jennifer J. Frost & Mia R. Zolna, Guttmacher Institute, to Senator Patty Murray, Ranking Member, Senate Health, Education, Labor and Pensions Committee, May 3, 2017, at 3, https://www.guttmacher.org/sites/default/files/article_files/guttmacher-murray-memo-2017.pdf. "Women in need of publicly funded contraceptive care" are defined as "[t]hose women who a) are younger than 20 or are poor or low-income (i.e., have a family income less than 250% of the federal poverty level) and b) are sexually active and able to become pregnant but do not want to become pregnant." *Id.* at 8.

33 *Id.* at 3.

34 *See, e.g.*, Carter et al., *supra* note 24, at 342; VandeVusse et al., *supra* note 21, at 10 ("Planned Parenthood facilities continue to exhibit the widest selection of contraceptive methods.").

Parenthood clinics vs. 52-77% of other types of clinics),[35] which is important so that people can have greater alternatives in choosing their preferred methods, avoid unintended pregnancies, and more effectively plan the timing of their pregnancies to maximize birth outcomes. Providing the full range of contraceptive options is also recommended by the American College of Obstetricians and Gynecologists ("ACOG"), the nation's leading organization of obstetricians and gynecologists.[36] In 2022-2023, 90% of Planned Parenthood centers provided at least 10 reversible contraceptive methods on-site, compared with 64-84% of other publicly funded clinics providing family planning services.[37]

28. Notably, Planned Parenthood health centers lead the way in providing intrauterine devices ("IUD"s) and contraceptive implants, both referred to as long-acting reversible contraception ("LARC") methods, to patients. LARCs are widely recognized as the most medically effective and cost-effective forms of contraception,[38] and ACOG has accordingly

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35 VandeVusse et al., *supra* note 21, at 14, App. Table 2; *see also* Healthy People 2030, *Family Planning*, *Overview and Objectives*, Office of Disease Prevention and Health Promotion, https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/family-planning (last visited June 2, 2025).

36 ACOG, Committee Opinion No. 615, *Access to Contraception*, 3 (Jan. 2015, reaffirmed 2022), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2015/01/access-to-contraception ("All FDA-approved contraceptive methods should be available to all insured women without cost sharing….").

37 VandeVusse et al., *supra* note 21, at 14, App. Table 2.

38 ACOG, Committee Opinion No. 186, *Long-Acting Reversible Contraception Implants and Intrauterine Devices* (Nov. 2017, reaffirmed 2024), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2017/11/long-acting-reversible-contraception-implants-and-intrauterine-devices (characterizing implants and IUDs as among the most effective methods of contraception); James Trussell et al., *Cost Effectiveness of Contraceptives in the United States*, 79 Contraception 5, 13 (2009); Paul D. Blumenthal et al., *Strategies to Prevent Unintended Pregnancy: Increasing Use of Long-Acting Reversible Contraception*, 17 Human Reproduction Update 121, 131 (2011).

recommended that clinicians encourage appropriate candidates to consider LARCs.[39] As of 2022-2023, Planned Parenthood health centers are more likely than other publicly funded health centers providing family planning services, including FQHCs, to offer a patient a LARC method (99% of Planned Parenthood clinics versus 64-84% of other types of clinics).[40]

29. Planned Parenthood health centers are also more likely than other publicly funded clinics providing family planning services to offer same-day LARC insertion,[41] a practice also recommended by ACOG.[42] Same-day LARC insertion is widely viewed as an essential component of effective family planning, because it eliminates the time and cost associated with follow-up visits and the risk that patients will be unable to return at a later time or will become pregnant in the interim.[43] Planned Parenthood's role in providing such effective methods of contraception is essential in helping to reduce the number of unintended and mistimed pregnancies.

30. Planned Parenthood health centers also stand out for their emergency contraception offerings. They are more likely than other types of publicly funded family planning providers to

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39 *Id.*

40 VandeVusse et al., *supra* note 21, at 14.

41 *Id.* at 7, 15, App. Table 3.

42 ACOG, Committee Opinion No. 615, *supra* note 36, at 4 ("Another common practice is requiring one medical appointment to discuss initiation of a LARC method and a second for placement of the device … Clinicians are encouraged to initiate and place LARC in a single visit as long as pregnancy may be reasonably excluded").

43 M. Antonia Biggs et al., *California Family Planning Health Care Providers' Challenges to Same-Day Long-Acting Reversible Contraception Provision*, 126 Obstetrics & Gynecology 338, 338 (2015) ("Same-day insertion protocols lessen patient burden, costs associated with additional visits, and the risk of experiencing an unintended pregnancy between the initial and subsequent visit."); *Bridging the Divide: Current Research and Policy on Long-Acting Reversible Contraception (LARC): Key Points for Policymakers*, Jacobs Institute of Women's Health, 8 (2016), https://jiwh.publichealth.gwu.edu/sites/g/files/zaxdzs6301/files/2023-09/larc_key_points.pdf (some women who would like to use a LARC method may not be able to return for a return visit for insertion).

offer emergency contraceptive pills (100% compared to 68-93% among other publicly funded clinics).[44] They are also more likely to dispense or prescribe oral emergency contraceptives ahead of time, so they are readily available to patients when needed without travel or wait times.[45] Planned Parenthood facilities are also more likely than others to offer copper IUDs as a method of emergency contraception.[46]

31. In addition to providing a broader range of contraceptive methods, according to a 2015 study, Planned Parenthood health centers were more likely than all other types of publicly funded clinics to implement contraceptive counseling protocols, which help patients maximize their ability to use their method of contraception effectively.[47] In 2022-2023, Planned Parenthood health centers were also more likely than all other provider types to offer at least a twelve-month pill supply when providing oral contraceptives, which prevents patients from having inadequate

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44 VandeVusse et al., *supra* note 21, at 14, Table 2.

45 *Id.* at 7 ("Planned Parenthood facilities were most likely to carry out this advanced provision of emergency contraception (81%), while FQHCs were the least likely (28%)"); *see also* ACOG, Frequently Asked Questions No. 114, Emergency Contraception (last updated April 2025), https://www.acog.org/womens-health/faqs/emergency-contraception (individuals can get emergency contraceptive pills ahead of time so they are available if needed).

46 VandeVusse et al., *supra* note 21, at 14, App. Table 2; ACOG, Frequently Asked Questions No. 114, *supra* note 45 (copper IUD is most effective form of emergency contraception).

47 *See, e.g.*, Carter et al., *supra* note 24, at 342-43, Table 2.

protection if they are unable to return for additional supplies.[48] Nearly all (98%) Planned Parenthood health centers used the quick-start protocol for oral contraceptives,[49] compared with 50-76% for all other clinic types.[50] Nearly all (98%) Planned Parenthood health centers dispense oral contraceptives without a pelvic exam,[51] which historically was a precondition for potential contraceptive patients, but are now considered by broad medical consensus to be unnecessary in most cases.[52] That figure compares favorably with 54-79% for all other clinic types.[53] This is important because the requirement of a pelvic exam, which involves instruments being placed in

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[48] VandeVusse et al., *supra* note 21, at 15, Table 3; ACOG, Committee Opinion No. 788, *Over-the-Counter Access to Hormonal Contraception* (2012, reaffirmed 2025), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/10/over-the-counter-access-to-hormonal-contraception ("Access to multiple OCP packs at one time … results in higher rates of continuation."); Diana Greene Foster et al., *Number of Oral Contraceptive Pill Packages Dispensed and Subsequent Unintended Pregnancies*, 117 Obstetrics & Gynecology 566, 569 (2011) ("Dispensing a 1-year supply [of oral contraceptives, as opposed to a 1-month or 3-month supply] is associated with a 30% reduction in the odds of conceiving a pregnancy in the subsequent year and a 46% reduction in the odds of an abortion….").

[49] The quick-start protocol, *i.e.*, starting contraceptive use on the day of an office visit, improves initial continuation rates for use of oral contraceptives. *U.S. Selected Practice Recommendations for Contraceptive Use, 2013*, CDC, 62 Morbidity & Mortality Wkly. Rep., 23 (2013), https://www.cdc.gov/mmwr/pdf/rr/rr62e0614.pdf.

[50] VandeVusse et al., *supra* note 21, at 15, App. Table 3.

[51] *Id.*

[52] Loretta Gavin et al., *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*, 63 Morbidity & Mortality Wkly. Rep., No. 4, 11 (2014), https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf. Pelvic exams can cause fear and discomfort and are "not needed routinely to provide contraception safely to a healthy client."; *see also* ACOG, Committee Opinion No. 615, *supra* note 36, at 4 ("There is no medical or safety benefit to requiring routine pelvic examination or cervical cytology before initiating hormonal contraception. The prospect of such an examination may deter a woman, especially an adolescent, from having a clinical visit that could facilitate her use of a more effective contraceptive method than those available over the counter.").

[53] VandeVusse et al., *supra* note 21, at 15, App. Table 3. In general, family planning-focused providers, like Planned Parenthood, are more likely than primary care/multi-specialty providers, like most FQHCs, to not misinform clients that pelvic exams or STI tests were necessary prior to contraceptive initiation.

the vagina, can be a significant deterrent for some patients to seek care, especially those who are victims of sexual assault.

32. Planned Parenthood health clinic's broad range of available contraceptive methods, coupled with its client-centered counseling and advising, provide patients with the flexibility to determine the preferred, client-centered family planning care treatment for their lifestyles.

3. Planned Parenthood Health Centers Readily Provide STI Testing and Treatment

33. In addition to the provision of contraceptives, Planned Parenthood health centers play an important public health role in screening for human immunodeficiency virus ("HIV") and other STIs. In 2023, Planned Parenthood health centers provided 5,132,330 STI tests and treatments, among which included 769,851 HIV tests.[54] Planned Parenthood health centers are more likely to provide pre-exposure prophylaxis ("PrEP"), a medication taken by HIV-negative individuals to significantly reduce the risk of acquiring HIV.[55] 97% of Planned Parenthood health centers offer PrEP for patients, compared to only 33% of health departments and 69% of FQHCs.[56] In providing these tests and treatments, according to a 2012 study, Planned Parenthood health centers were more likely to use rapid-result testing for HIV (tests that provide results more quickly than other forms of testing) than other publicly funded family planning clinics, such as FQHCs, public health departments, and hospital outpatient clinics, enabling patients to begin treatment more quickly.[57] And, the experience by Planned Parenthood health clinics in promoting and

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[54] Planned Parenthood Federation of America, *A Force for Hope: Planned Parenthood Annual Report 2023-2024*, *supra* note 14, at 23.

[55] VandeVusse et al., *supra* note 21, at 8, 16, Table 4.

[56] *Id.*

[57] Frost et al., *Variation in Service Delivery Practices Among Clinics Providing Publicly Funded Family Planning Services in 2010*, *supra* note 27, at 12.

delivering PrEP has provided valuable insight to increasing access to and culturally competent communications about PrEP.[58]

4. Planned Parenthood Members Provide Accessible Services for Adolescents

34. Adolescents and young adults are populations that often have difficulty obtaining family planning services, and Planned Parenthood health centers offer high quality care to the substantial number of adolescents and young adults they serve.[59] For example, in 2015, 97% of Planned Parenthood health centers provided LARCs to adolescent patients, compared to 57-76% of other types of publicly funded family planning providers.[60] One study found that certain facility practices that are targeted to teens and young adults, such as more flexible hours, teen-friendly decor, online scheduling, and social media usage, were more prevalent at Planned Parenthood health centers than other providers.[61] In addition, researchers suggest that Planned Parenthood's name recognition may avoid some of the lack-of-knowledge barriers that prevent adolescents from

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[58] Brittany Wilbourn et al., *Preexposure Prophylaxis Implementation in a Reproductive Health Setting: Perspectives From Planned Parenthood Providers and Leaders*, 24 Health Promotion Practice 764 (2022) [doi:10.1177/15248399221086616].

[59] Katherine H. Mead et al., *The Role of Federally Qualified Health Centers in Delivering Family Planning Services to Adolescents*, 57 J. Adolescent Health 87, 87-88 (2015) (summarizing reasons why adolescents have difficulty obtaining adequate family planning care); Megan L. Kavanaugh et al., *Meeting the Contraceptive Needs of Teens and Young Adults: Youth-Friendly and Long-Acting Reversible Contraceptive Services in U.S. Family Planning Facilities*, 52 J. Adolescent Health 284, 286 (2013).

[60] Mia R. Zolna & Jennifer Frost, *Publicly Funded Family Planning Clinics in 2015: Patterns and Trends in Service Delivery Practices and Protocol*, Guttmacher Inst., 22, fn. 19 (Nov. 2016), https://www.guttmacher.org/sites/default/files/report_pdf/publicly-funded-family-planning-clinic-survey-2015_1.pdf (last visited July 3, 2025).

[61] Kavanaugh et al., *supra* note 59, at 286. In 2022-2023, Planned Parenthood health centers were more likely than other publicly funded family planning clinics to offer extended (evening and/or weekend) clinic hours (70% compared to 3-53%). VandeVusse et al., *supra* note 21, at 13, App. Table 1.

obtaining care at other publicly funded providers.[62] One study found that a young woman's likelihood of becoming a mother and dropping out of high school decreased with a local presence of a Planned Parenthood health center.[63]

II. OTHER PUBLICLY FUNDED HEALTH CLINICS WILL NOT FILL THE GAP LEFT BY PLANNED PARENTHOOD MEMBERS' EXCLUSION FROM MEDICAID

35. By excluding Planned Parenthood Members from federal Medicaid funding upon enactment, Section 71113 creates an immediate health care crisis for over a million patients, and will place enormous strain on other publicly funded health care providers.[64] The loss of Medicaid funding could force over a million family planning patients who previously received care at Planned Parenthood health centers to seek care at alternative sites such as FQHCs. But, although FQHCs are a large and important part of the nation's primary health care safety-net, they will not be able to meet the need of providing care to Planned Parenthood Members' Medicaid patients

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62 Mead et al., *supra* note 59, at 87, 92.

63 Katherine Hicks-Courant & Aaron Schwartz, *Local Access to Family Planning Services and Female High School Dropout Rates*, 127 Obstetrics & Gynecology 699, 703 (2016), [doi: 10.1097/AOG.0000000000001344]. This study found that the abortion services provided at some Planned Parenthood clinics "did not drive the association between the clinics and reduced high school dropout rates."

64 Press Release, Guttmacher Institute, Federally Qualified Health Centers Could Not Readily Replace Planned Parenthood (updated June 4, 2025), https://www.guttmacher.org/news-release/2025/federally-qualified-health-centers-could-not-readily-replace-planned-parenthood; Sara Rosenbaum, *Planned Parenthood, Community Health Centers, And Women's Health: Getting the Facts Right*, Health Affairs (Sept. 2, 2015), http://healthaffairs.org/blog/2015/09/02/planned-parenthood-community-health-centers-and-womens-health-getting-the-facts-right.

because Section 71113 does not provide a reasonable accommodation time for patients and clinics to make adjustments.[65]

36. In my opinion, it is unrealistic to suggest that FQHCs (or any other alternative sites, such as public health clinics, hospitals, etc.) could possibly ramp up services quickly enough to fill the sudden gap left by disqualifying Planned Parenthood Members from federal Medicaid reimbursement.

37. There are at least four critical flaws with the assumption that family planning services can be transferred from Planned Parenthood health centers to FQHCs or other publicly funded health care providers without any significant loss of care.

38. The four critical flaws are: (1) it would take substantial additional time for FQHCs to hire staff and make other changes needed to meet the needs of over a million new family planning patients; (2) FQHCs may not be located near Planned Parenthood health centers, so they may not be accessible to large numbers of patients displaced from Planned Parenthood; (3) FQHCs do not offer the same range of reproductive services that Planned Parenthood health centers offer, so transferring patients may not be able to obtain the type of care they need, or else receive care from a provider with less expertise in the services sought; and (4) any additional funding (if any) would not help to compensate for the loss of Planned Parenthood services because it would take the federal administering agency months to even allocate new funds to FQHCs.

39. The net result is that FQHCs could not realistically respond in a timely fashion to fill the gap left by the barring of Medicaid reimbursement to Planned Parenthood health centers.

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[65] Press Release, Guttmacher Institute, *supra* note 64; Sara Rosenbaum, *Can Community Health Centers Fill the Health Care Void Left by Defunding Planned Parenthood?*, Health Affairs (Jan. 27, 2017), http://healthaffairs.org/blog/2017/01/27/can-community-health-centers-fill-the-health-care-void-left-by-defunding-planned-parenthood.

Over a million patients would likely experience a serious gap in access to family planning services, which could result in increases in unplanned pregnancies and births as well as other health problems, such as untreated STIs or cancers detected too late due to missed cancer screenings. For those patients who use Planned Parenthood Members as their primary health care providers, the denial of Medicaid reimbursement to Planned Parenthood Members may also lead to other health impacts.

A. FQHCs Would Require Substantial Time to Meet the Needs of Over a Million New Family Planning Patients

40. *First*, to serve Planned Parenthood Members' existing Medicaid patients, FQHCs would have to immediately recruit and hire medical staff, as well as expand their space (e.g., exam rooms) and stock of supplies, such as intrauterine devices or oral contraceptives. As explained before, given that an average Planned Parenthood center serves 2,640 contraceptive patients per year while an average FQHC site serves 320,[66] an FQHC near a Planned Parenthood center that closed down would need to increase the number of contraceptive patients served by almost ten times in order to absorb those who can no longer go to Planned Parenthood because of Section 71113.

41. Planned Parenthood Members' exclusion from Medicaid will likely result in patients who are motivated to protect against unintended pregnancies to seek contraceptive care from other providers. For example, FQHC sites offering contraceptive care would have to, virtually overnight, increase their capacity to provide these services by 56%—an additional one million contraceptive clients.[67] Public health department sites offering contraceptive care would

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66 Press Release, Guttmacher Institute, *supra* note 64.

67 *Id.*

have to increase their capacity to provide these services by 28%—an additional 168,000 contraceptive patients.[68] Hospital sites offering contraceptive care would have to increase their capacity to provide these services by 53%—an additional 344,000 contraceptive patients.[69] And other sites offering contraceptive care would have to increase their capacity to provide these services by 55%—an additional 189,000 contraceptive patients.[70] Not included in these numbers are the likely increase in wait times, decreased access nearby clinics, and gaps in the services provided as a result of Planned Parenthood Members' absence.[71]

42. But FQHCs already struggle to fill existing vacancies and frequently suffer staffing shortages owing to their locations in medically underserved areas. By statute, FQHCs only operate in areas that are designated as medically underserved areas, even before Section 71113 went into effect, or as health professional shortage areas, so they typically struggle to hire trained health staff. Almost all FQHCs (95%) have at least one clinical vacancy at any given time.[72] More than two thirds (69%) have a vacancy for a family physician, half (50%) have a vacancy for a nurse practitioner, and have a 41% vacancy for a registered nurse.

43. Furthermore, it can be particularly difficult and time-consuming for FQHCs to fill staff vacancies for reproductive health providers. For example, the average time to fill an

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68 *Id.*

69 *Id.*

70 *Id.*

71 *See infra* Section I.B.

72 *Staffing the Safety Net: Building the Primary Care Workforce at America's Health Centers*, National Association of Community Health Centers (March 2016), https://hcpsocal.org/wp-content/uploads/2014/05/NACHC_Workforce_Report_2016.pdf.

obstetrician/gynecologist position at an FQHC is about 11 months.[73] When FQHCs have challenges meeting their current staffing needs, it is inherently impracticable for them to rapidly meet new and sudden unanticipated needs to serve over a million patients who would be displaced from Planned Parenthood health centers (as well as other patients who might be affected if Planned Parenthood health centers must close or curtail services).

44. This point is illustrated by a study in which researchers interviewed alternative providers, such as FQHCs, in the vicinity of five Texas Planned Parenthood clinics to learn if they had the capacity to take in patients that might lose Medicaid funding at Planned Parenthood clinics.[74] The alternative sites generally reported they were already at or close to capacity and would not be able to serve large numbers of additional family planning patients. For example, survey respondents noted that their nurse practitioners or physicians already had full caseloads, and a new patient might need to wait for months for an appointment.

45. Similar findings were reported from a 2021 qualitative interview study that evaluated access to care after Planned Parenthood Members were excluded from the Texas

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[73] *Id*. Rural family planning clinics are more likely to be understaffed and under resourced, compounding the crisis for rural FQHCs. In 2016, 13% of community health centers reported a vacancy for an obstetrician-gynecologist, and between 2006-2008, only 0.6% to 1.4% of all recent US residency graduates went on to practice in rural health centers or FQHCs. Anita Y. Cheng, *Community Health Center Engagement and Training During Obstetrics and Gynecology Residency*, 11 Jour. Graduate Medical Educ., 513 (Oct. 2019) [doi: 10.4300/JGME-D-19-00039.1]; *see also* Emma Pliskin et al., *Rural and Urban Women Have Differing Sexual and Reproductive Health Experiences*, Child Trends, (Sept. 15, 2022) https://www.childtrends.org/publications/rural-and-urban-women-have-differing-sexual-and-reproductive-health-experiences (last visited July 3, 2025).

[74] Leighton C. Ku et al, *Deteriorating Access to Women's Health Services in Texas: Potential Effects of the Women's Health Program Affiliate Rule*, Geiger Gibson/RCHN Community Health Foundation Research Collaborative: Policy Research Brief No. 31 (2012), https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1000&context=sphhs_policy_ggrchn.

Medicaid program, discussed in more detail below. The study found Planned Parenthood Medicaid patients experienced challenges accessing care elsewhere, finding other providers, and getting evidence-based care, leading to delayed or forgone care, and emotional distress.[75]

B. FQHCs May Not Be Practically Accessible To Large Numbers Of Patients Displaced From Planned Parenthood

46. *Second*, even if FQHCs did have sufficient capacity, many current Planned Parenthood patients would still be unable to obtain care at those health centers.

47. While FQHCs are an important part of this country's health care safety net, in 2020, only 56% of FQHC sites nationwide reported offering contraceptive care to at least 10 women per year—the threshold at which clinics are considered part of the network of safety-net contraceptive providers. FQHC sites each serve an average of 330 female contraceptive patients annually; health department sites serve 320 annually; centers operated by hospitals serve 640 annually; and centers operated by other types of agencies serve 410 annually. By contrast, Planned Parenthood Member health centers each serve an average of 2,640 female contraceptive clients annually.[76]

48. FQHCs and Planned Parenthood health centers are not always located in the same areas, and in many counties the patient population is heavily or even exclusively reliant on Planned Parenthood health centers for reproductive health care. According to 2015 data, in 238 (57%) of the 415 counties with a Planned Parenthood health center, Planned Parenthood served at least half of all safety-net contraceptive patients.[77] Approximately 4.8 million women—24% of all women

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75 Anna Chatillon et al., *Access to care following Planned Parenthood's termination from Texas' Medicaid Network: A qualitative study*, 128 Contraception 110, 141 (2023), https://www.contraceptionjournal.org/article/S0010-7824(23)00235-4/fulltext.

76 Press Release, Guttmacher Institute, *supra* note 64.

77 Zolna & Frost, *supra* note 60, at 2.

in need of publicly funded contraceptive care—live in those counties.[78] In 203 counties, FQHCs would have to triple their contraceptive patient workloads in order to provide services for the patients currently being treated at Planned Parenthood health centers.[79] As of 2017, in 54 counties with Planned Parenthood health centers, there were no FQHCs at all.[80] And in 38 of these counties, Planned Parenthood health centers are the sole publicly funded source of reproductive health care services.[81] Analysis by the Congressional Research Service from 2017 reached a similar conclusion: despite the large number of FQHC sites, there are a number of areas in which a Planned Parenthood health center exists, but there is no FQHC in the same county.[82]

49. Thus, even Planned Parenthood Members' very large share of the aggregate provision of reproductive health services does not fully reflect how important Planned Parenthood health centers are to the communities that depend on them as Medicaid providers. In many parts of the country, Planned Parenthood is not just the predominant or preferred provider of reproductive health services—it is the *only* publicly funded option available. Patients in those and surrounding counties may have to travel more than 100 miles to obtain care at an alternative provider, and many of those patients will be unable or unwilling to do so, especially lower-income

78 *Id.* at 3.

79 *Id.* at 5.

80 *Id*.

81 *Id*.

82 Elayne J. Heisler and Victoria L. Elliott, Cong. Rsch. Serv., R44295, Factors Related to the Use of Planned Parenthood Affiliated Health Centers (PPAHCs) and Federally Qualified Health Centers (FQHCs), 25, Table 6 (May 18, 2017).

patients who are likely to have difficulty in finding transportation and meeting child-care and work responsibilities.[83]

C. FQHCs Do Not Offer The Same Range Of Reproductive Services That Planned Parenthood Centers Offer

50. *Third*, Planned Parenthood health centers and FQHCs are not substitutes for one another in terms of the services they offer. Under Section 330 of the Public Health Service Act, FQHCs must provide comprehensive primary care services to all patients. Thus, their limited resources must be directed not just to reproductive care, but to all other primary care and preventive needs, including pediatric and geriatric services, mental health, and other services. In 2022-2023, 100% of Planned Parenthood health centers had a primary focus on reproductive health, compared with 8% of FQHCs.[84] Unsurprisingly, then, women of reproductive age are only about a quarter (26%) of all FQHC patients, whereas they represent more than 85% of all Planned Parenthood patients.

51. Research has shown that patients prefer to receive care at specialized clinics, like Planned Parenthood health centers, because such clinics can offer better or faster services such as having oral contraceptives available on site or have same day IUD insertion available.[85] Shifting

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[83] For example, a 2021 study found that increased driving time required for treatment led to an increased likelihood of cost-related healthcare avoidance, reduced likelihood of ever having had a clinical breast examination, and past-year mammogram receipt among female Ohio residents following restrictions on public funding led to clinical closures. Jacqueline Ellison et al., *The Impact of Driving Time to Family Planning Facilities on Preventive Service Use in Ohio*, 60 Am J. Prev. Med. 4 (2021).

[84] VandeVusse et al., *supra* note 21, at 13, App. Table 1.

[85] Jennifer J. Frost et al., *Specialized Family Planning Clinics in the United States: Why Women Choose Them and Their Role in Meeting Women's Health Care Needs*, 22 Women's Health Issues 519 (2012).

to other facilities means that patients may not receive the full range and quality of family planning services that they have come to expect at Planned Parenthood health centers.

52. Research by Guttmacher Institute shows the limitations of FQHCs in this area.[86] As of 2023, only 52% of FQHCs offered the full range of reversible contraceptive services, compared with 94% of Planned Parenthood clinics.[87] In addition, while almost every Planned Parenthood health center offers same day IUD insertion and oral contraceptive pills, only 38% of FQHCs offer same day IUD insertion, and about 50% of FQHCs offer same day oral contraceptive pills.[88]

D. It Would Take The Federal Administering Agency Months To Allocate New Funds To FQHCs

53. *Fourth*, Section 71113 does not explain how any additional FQHC funding is to be allocated, and there are significant logistical difficulties in ensuring that the funding is correctly allocated to clinics where there is additional need stemming from the disruption of services at Planned Parenthood health centers. It would not make sense for HRSA, the federal funding agency, to simply increase funding to all FQHCs—most are not in the service areas of Planned Parenthood health centers. Moreover, as discussed above, they are unlikely to be operationally equipped to handle a rapid expansion even if they had additional funding.

54. It is my understanding that the additional funds for FQHCs must be allocated through a grant funding system. In practical terms, this means that HRSA would need to draft and issue a funding notice, receive grant applications from FQHCs, evaluate the applications to decide

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86 *See* VandeVusse et al., *supra* note 21.

87 *Id.* at 14, App. Table 2.

88 *Id.* at 15, App. Table 3.

which applications to fund, and then release the funds. Here, there is an additional challenge: If the reallocated funds are targeted to provide care to displaced Planned Parenthood patients to buttress the public health impact, then funds ought to be allocated to FQHCs that are close in location to Planned Parenthood health centers, which would require more specialized and time-consuming funding notices and applications.

55. To illustrate the time needed, on May 30, 2024, HRSA released a funding opportunity notice (HRSA-25-085) soliciting applications to support new FQHC service sites for the following fiscal year, beginning on June 1, 2025.[89] There is a significant gap between the announcement of funding availability and the date when funds became available.

56. Following passage of the 2025 Act, FQHCs will likely receive no further federal funds to help them provide service to the over a million patients who would no longer be able to receive those services at Planned Parenthood health centers.

57. In light of these four factors, the overall effect of Section 71113 will likely leave many patients with significantly reduced access to reproductive health care.[90]

58. Moreover, although I have thus far focused on the patients receiving services at Planned Parenthood health centers, Section 71113 will also have devastating effects on the low-income patients that currently receive their care at FQHCs. FQHCs are already stretched to capacity. As noted above, an average FQHC patient typically waits nine days for a general medical

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[89] U.S. Dep't of Health and Human Services, HRSA, *Notice of Funding Opportunity: New Access Points*, No. HRSA-25-085 (May 30, 2024), https://apply07.grants.gov/apply/opportunities/instructions/PKG00286780-instructions.pdf.

[90] Even if these patients were to identify viable alternatives to seeking care in FQHCs, they would likely encounter many of the same challenges as described above. It would be important to conduct studies to better document the full impact of Section 71113.

appointment at FQHCs.[91] Because of the difficulty in expanding capacity rapidly, I expect that the typical appointment delay at FQHCs for a family planning patient in areas affected by the loss of Planned Parenthood health centers could exceed one month. Many patients would be discouraged by such a long delay and go without contraception, increasing the risk of an unplanned pregnancy or untreated sexually transmitted infection.[92]

59. The delays would affect not only new family planning patients—those previously served by Planned Parenthood—but also those already receiving a range of care provided at FQHCs. If there is a sudden surge in the number of appointments at an FQHC, the FQHC will typically attempt to serve all patients in an equivalent fashion. If FQHCs are to serve new patients with the same level of staff and resources they had before, then all patients, whether new or established, will have to wait longer for appointments. This can create delays not only in people getting family planning services, but also in delays for other medical care too, such as care for diabetes or heart disease, further burdening health care infrastructure for patients with low incomes.

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[91] Brendan Saloner et al., *The Availability of New Patient Appointments for Primary Care at Federally Qualified Health Centers: Findings From an Audit Study*, The Urban Institute Health Policy Center (April 7, 2014), https://www.urban.org/sites/default/files/publication/22496/413088-The-Availability-of-New-Patient-Appointments-for-Primary-Care-at-Federally-Qualified-Health-Centers-Findings-From-an-Audit-Study.PDF.

[92] Brooke Whitfield et al., *Timely Access to Contraception at Medicaid Providers Following the Exclusion of Planned Parenthood from Texas' Medicaid Program*, Univ. of Tex. at Austin, Tex. Policy Eval. Proj., at 3 (Jan. 2022) https://sites.utexas.edu/txpep/files/2022/01/TxPEP-research-brief-Planned-Parenthood-Medicaid.pdf.

III. BARRING PLANNED PARENTHOOD FROM FEDERAL MEDICAID REIMBURSEMENTS WILL LEAD TO ADVERSE PUBLIC HEALTH OUTCOMES

60. In my opinion, the overall effect of Section 71113 will thus be to reduce access to high quality health care, particularly for low-income Americans, and to increase the strain on publicly funded providers at the precise moment they are expected to serve an influx of new patients who can no longer receive services from Planned Parenthood Members.

61. Already, publicly funded providers struggle to meet the demand for contraceptive services and supplies. A study conducted in 2020 found that publicly supported family health care providers served only 39% of all women who likely needed support for contraceptive services.[93] In other words, only 7 million out of 19 million women who likely needed public support received these vital health care services.[94]

62. If patients lose access to the health care services or are delayed in accessing care that they currently obtain at Planned Parenthood facilities, the public health consequences will be numerous and severe. These adverse consequences are likely to include, among others, more unintended and therefore riskier pregnancies, potentially resulting in health problems for the women, as well as their infants and children. STIs will also go undetected or be detected later, leading to higher rates of STIs and more severe consequences for patients experiencing these diseases, such as pelvic inflammatory diseases ("PID") and future infertility. Those adverse consequences are likely to be felt most intensely by historically underserved populations; as studies have shown, people of color in the United States are disproportionately unable to gain access to

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93 Frost et al., *Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Use, 2020*, *supra* note 17, at Figure 5.

94 *Id.*

and benefit from high-quality health care.[95] This crisis will be further compounded by other steps the federal government is taking to deprive Planned Parenthood Members of other funding streams, such as withholding Title X funds and restrictions on funds for sex education programs that Planned Parenthood Members provide in community settings.

A. The Number of Unintended Pregnancies and the Rate of Related Adverse Health Outcomes and Costs Will Likely Increase

63. Reduced access to Planned Parenthood health centers will lead to reduced access to contraceptives and, in particular, to the most effective forms of contraceptives, which will in turn lead to an increased number of unintended or mistimed pregnancies. Unintended pregnancies are themselves an undesirable health outcome, and unintended or mistimed pregnancies also may lead to other adverse health outcomes for both mother and child. When the number of unintended pregnancies rises, the number of abortions also rises. Finally, when the costs of unintended pregnancies are borne by taxpayer-funded systems, those costs far outstrip the costs of providing contraceptive services.

1. The Number of Unintended Pregnancies Will Likely Increase

64. Patients who lose access to contraceptive services at Planned Parenthood health centers are likely to use less effective forms of birth control. In a study encompassing a variety of clinic types, including Planned Parenthood clinics, participating in California's publicly funded family planning program (Family PACT), individuals were asked what they would do if they had

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[95] *See generally Healthy People 2020: An Opportunity to Address Societal Determinants of Health in the U.S.*, Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020 (July 26, 2010), https://health.gov/sites/default/files/2021-11/Committee%27s%20Report%20on%20Healthy%20People%202020-%20An%20Opportunity%20to%20Address%20Societal%20Determinants%20of%20Health.pdf.

to pay for their family planning services.[96] Responses indicated that patients would use less effective means of contraception. Specifically, patients reported that their use of low-efficacy methods, such as condoms, would nearly double (from 25% to 46%).[97] Patients' projected use of medium-efficacy methods, such as contraceptive injections, oral contraceptives (OCs), patch, and ring, would decrease from 63% to 44%.[98] Patients' use of high-efficacy methods, such as IUDs, contraceptive implants, and sterilization, would decrease from 11% to 7%.[99] Use of no method would increase from 2% to 3%.[100]

65. The decrease in the use of high-efficacy contraception methods and the increase in use of low-efficacy methods will result in more unintended and mistimed pregnancies. High-efficacy methods have failure rates of less than 1%, meaning that fewer than 1% of women using these methods will experience an unintended pregnancy within the first year of use.[101] Medium-efficacy methods have failure rates of 4-7%, because some patients miss or delay injection or

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96 M. Antonia Biggs et al., *Findings from the 2012 Family PACT Client Exit Interviews*, Bixby Center for Global Reproductive Health, 54 (June 2014).

97 *Id.* at 53. Low-efficacy methods include condoms, diaphragms, and other barrier methods; natural family planning; abstention; and emergency contraception. *Id.* at 34.

98 *Id.* at 34, 53.

99 *Id.*

100 *Id.* at 34, 54.

101 *Contraception and Birth Control Methods*, CDC (Aug. 6, 2024), https://www.cdc.gov/contraception/about/index.html.

ingestion of the pill.[102] Failure rates for low-efficacy methods, including male condoms, are 13% and higher.[103] Using no method of contraception has a failure rate of 85%.[104]

66. In 2015, Planned Parenthood Members' provision of contraceptive services averted 430,000 unintended pregnancies.[105] Section 71113, by decreasing access to Planned Parenthood Members' extensive family planning services, which include offering highly effective LARCs at higher rates than other providers, will likely increase the number of unintended and mistimed pregnancies.

2. Unintended Pregnancies Will Have Adverse Health Impacts on Mothers and Children

67. There are several risks to infants and mothers that occur more frequently with unintended pregnancies than with planned pregnancies. In some instances, preexisting health conditions, such as having recently given birth or diabetes, make it important for a person to be

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102 *Id.*

103 *Id.*; *see also* ACOG, Committee Opinion No. 642, *Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy*, at 2 (October 2015), https://journals.lww.com/greenjournal/abstract/2015/10000/committee_opinion_no__642__increasing_access_to.52.aspx.

104 James Trussell, *Contraceptive Failure in the United States*, 83 Contraception 397, 398 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3638209/pdf/nihms458000.pdf.

105 *Unintended Pregnancies and Abortions Averted by Planned Parenthood*, Guttmacher Inst. (June 13, 2017), https://www.guttmacher.org/infographic/2017/unintended-pregnancies-and-abortions-averted-planned-parenthood-2015; s*ee also* M. Antonia Biggs et al., *Cost-Benefit Analysis of the California Family PACT Program for Calendar Year 2007*, Bixby Center for Global Reproductive Health, 16, 17, Fig. 1 (2010), https://www.ansirh.org/sites/default/files/publications/files/familypactcost-benefitanalysis2007_2010apr_featured.pdf (in California, across all publicly funded contraceptive providers—including Planned Parenthood—it was estimated that, for every seven women who received publicly funded contraceptive services, two pregnancies were averted. There, in one year, it was estimated that provision of contraceptive services to 998,084 clients averted 286,700unintended pregnancies.).

able to delay becoming pregnant.[106] If a person with these conditions fails to delay becoming pregnant until the conditions are properly managed, there is a risk of a range of adverse health impacts, including pregnancy loss, still-births, pre-term births, infant size that is either too small or too large relative to gestational age, birth defects, and increased risk of hypoglycemia (low blood sugar) or respiratory distress for the baby.[107]

68. The effects of unintended pregnancies on infants have been shown to persist into childhood and even adulthood. For example, children from unintended pregnancies are more likely to experience poor mental and physical health during childhood and have lower educational attainment and more behavioral issues in their teen years.[108]

69. In addition, because a person experiencing an unintended pregnancy may not immediately be aware that they are pregnant, a person with an unintended pregnancy is more likely to receive no prenatal care or to receive care later in their pregnancies.[109] They are also more

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[106] ACOG, Committee Opinion No. 654, *Reproductive Life Planning to Reduce Unintended Pregnancy* (2016), https://journals.lww.com/greenjournal/abstract/2016/02000/committee_opinion_no__654__reproductive_life.53.aspx#:~:text=In%20order%20to%20reduce%20the,use%20of%20all%20contraceptive%20methods; ACOG Practice Bulletin No. 230 (2021), *Obesity in Pregnancy*, https://journals.lww.com/greenjournal/abstract/2021/06000/obesity_in_pregnancy__acog_practice_bulletin,.38.aspx; ACOG, Frequently Asked Questions No. 142, Diabetes and Women (2016), https://sa1s3.patientpop.com/assets/docs/87560.pdf. Planned Parenthood providers discuss such conditions with patients to help inform physicians' and patients' discussions regarding timing and planning for a safe pregnancy. *Pre-Pregnancy Health and Planning*, https://www.plannedparenthood.org/learn/pregnancy/pre-pregnancy-health; *see also* Healthy People 2030, *supra* note 35.

[107] *See* ACOG sources cited *supra* note 106.

[108] *Family Planning, Reduce the proportion of unintended pregnancies — FP-01*, Office of Disease Prevention and Health Promotion, https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/family-planning/reduce-proportion-unintended-pregnancies-fp-01 (last visited July 2, 2025); *see also* ACOG, Committee Opinion No. 654, *supra* note 106.

[109] Diana Cheng et al., *Unintended Pregnancy and Associated Maternal Preconception, Prenatal and Postpartum Behaviors*, 79 Contraception 194, 196 (2009).

likely to smoke and consume alcohol during pregnancy, to be depressed during pregnancy, and to experience domestic violence during pregnancy—all issues that contribute to worse health outcomes.[110]

70. Unintended pregnancies occur across all income levels, races, and ages, but research shows that the rates of unintended pregnancies are higher among certain groups.[111] For example, 71% of pregnancies to mothers ages 15 to 19 are unintended.[112] Women whose income is below the federal poverty level and black women and Latinas also have higher rates of unintended pregnancies than other demographic groups.[113] Many of the reasons these populations suffer disparate effects from unintended pregnancies are underlying factors that Planned Parenthood works hard to counteract, such as cost of services combined with limited insurance coverage, family planning clinic locations and hours that are not convenient, and lack of youth-friendly and client-centered reproductive health services.[114] Removing Planned Parenthood

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110 *Id.*; *see also* ACOG, Committee Opinion No. 654, *supra* note 106; Mary K. Ethen et al., *Alcohol Consumption by Women Before and During Pregnancy*, 13 Maternal Child Health J., 274, 277 (2009); Christie A. Lancaster et al., *Risk Factors for Depressive Symptoms During Pregnancy: A Systematic Review*, 202 Am. J. Obstetrics & Gynecology 5, 7, 11 (2010); Lois James et al., *Risk Factors for Domestic Violence During Pregnancy: A Meta-Analytic Review*, 28 Violence & Victims 359, 368-69 (2013).

111 *See, e.g.*, Blumenthal et al., *supra* note 38, at 123.

112 Lauren M. Rossen et al., *Updated Methodology to Estimate Overall and Unintended Pregnancy Rates in the United States, National Center for Health Statistics*, CDC, 19 (Apr. 2023), https://www.cdc.gov/nchs/data/series/sr_02/sr02-201.pdf.

113 *Id.*; Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008-2011*, 374 N. Engl. J. Med. 843, 846-47 (2016); Jennifer J. Frost et al., Guttmacher Institute, *Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program*, 92 Milbank Q. 667, 668 (2014).

114 *See, e.g.*, Susan A. Cohen, *Abortion and Women of Color: The Bigger Picture*, 11 Guttmacher Pol'y Rev. 2, 4-5 (2008), https://www.guttmacher.org/sites/default/files/article_files/gpr110302.pdf; Mead et al., *supra* note 59, at 87-88.

Members from the already limited network of providers available to these patients and families will likely disproportionately harm already medically underserved populations.

71. Decreased access to contraceptives and the corresponding increase in the number of unintended pregnancies caused by excluding Planned Parenthood Members' care will likely result in an increased number of abortions.[115] Studies show that, as the rate of contraceptive use by unmarried women increased in the U.S. between 1982-2001, rates of unintended pregnancy and abortion for unmarried women also declined.[116] In addition, increased access to affordable contraceptives through the Affordable Care Act reduced the number of unintended pregnancies and the rate of abortions.[117] A study regarding California's Family PACT program estimated that provision of contraception to approximately 1,000,000 women and 100,000 men through that program in 2007 prevented approximately 122,200 abortions.[118] Similarly, when Iowa increased access to contraceptive services over the course of 2006-2008, studies found lower abortion rates.[119] It is likely that a decrease in contraceptive use will not only raise the rate of unintended

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115 Over 30% of unintended pregnancies end in abortion in the United States. Jonathan M. Bearak et al., *Country-specific Estimates of Unintended Pregnancy and Abortion Incidence: A Global Comparative Analysis of Levels in 2015–2019*, 7 BMJ Global Health 3 (2022) (Supplementary PDF, App. D).

116 Heather D. Boonstra et al., *Abortion in Women's Lives*, Guttmacher Inst., 18 (2006), https://www.guttmacher.org/sites/default/files/pdfs/pubs/2006/05/04/AiWL.pdf.

117 Matthew D. Solomon et al., *Effects of the Affordable Care Act on Contraception, Pregnancy, and Pregnancy Termination Rates*, 145(2) Obstetrics & Gynecology 196 (Feb. 2025), [doi: 10.1097/AOG.0000000000005796].

118 Biggs et al., *Cost-Benefit Analysis of the California Family PACT Program for Calendar Year 2007*, *supra* note 105, at 6, 16.

119 M. Antonia Biggs et al., *Did Increasing Use of Highly Effective Contraception Contribute to Declining Abortions in Iowa?*, 91 Contraception 167, 169 (2015).

pregnancy, but will also raise the rate of abortion, where it is legal after *Dobbs v. Jackson Women's Health Organization*.

3. Unintended Pregnancies Also Impose a Serious Fiscal Cost on Society

72. When considering the adverse public health consequences of intended and mistimed pregnancies, fiscal costs are a significant factor that are measurable and substantial for society as a whole. In 2016, more than $3 billion in public costs was spent on family planning and related sexual and reproductive health services (such as STI testing).[120] Those services were estimated to have averted approximately 2 million pregnancies, among other adverse health outcomes.[121] The estimated public costs associated with those pregnancies and outcomes—*i.e.*, maternity care, birth, infant care, miscarriages or abortions, and treating the effects of undetected STIs—would have been $15 billion, $14.3 billion of which is attributable to publicly covered maternity and infant care.[122] Accordingly, publicly funded family planning and related care saved nearly $12 billion in public costs.[123] In other words, for every $1 spent on family planning services, the public saved nearly five times that amount ($4.83) in costs associated with unintended pregnancies and other reproductive health issues.[124]

73. Eliminating Planned Parenthood health centers as a source of contraceptive care would have an outsized impact on cost-savings because they serve a large proportion of clients in

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120 Jennifer J. Frost et al., *Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Impact, 2016*, Guttmacher Inst., 20 (2019), https://www.guttmacher.org/sites/default/files/report_pdf/publicly-supported-fp-services-us-2016.pdf.

121 *Id.* at 18.

122 *Id.* at 20.

123 *Id.*

124 *Id.*

need of publicly funded family planning services, and because it provides clients with highly effective methods of contraception.

B. The Number of Sexually Transmitted Infections Will Likely Increase

74. In addition to contraceptive care, it is important to remember that hundreds of thousands of patients receive other important services, such as STIs and treatment, cervical and breast cancer screening, pregnancy testing and counseling, other primary-care related services, such as blood pressure screening, and mental health screening, from Planned Parenthood Members. Adults and adolescents are likely to have reduced access to these services as well, with the result that there are likely to be more undetected and untreated STIs and cancers, with other attendant serious consequences.

75. The preventive care provided by Planned Parenthood health centers in the STI testing and treatment field is highly cost effective and avoids financial burdens that would be borne by the public in Planned Parenthood's absence. For example, the 2016 analysis of publicly funded clinics described above found that the role of publicly funded clinics—including Planned Parenthood health clinics—in screening, testing, and preventing STIs during family planning visits saved an estimated $273 million taxpayer dollars that year, in the form of costs to treat PID or other results of untreated chlamydia or gonorrhea, HIV infections, and HPV sequelae for low-income populations.[125]

[125] Frost et al., *Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Impact, 2016*, *supra* note 120, at 20, Table 18.

76. Reduced access to Planned Parenthood health centers will lead to reduced access to testing, counseling, and treatment for STIs. This means that STIs will go undiagnosed or be diagnosed much later, which will both put those patients at greater health risk themselves and allow them to transmit the infection to more people.

77. In its most recent annual report, PPFA reported that its Members provided 769,851 HIV tests, 4,330,310 STI tests, 173,397 Pap tests; 16,824 HPV treatments, and 40,247 HPV vaccinations, 15,345 other STI prevention treatments, among other services.[126]

78. The Guttmacher Institute has developed a tool to estimate the health benefits and cost savings associated with publicly funded family planning.[127] Using that tool and the list of services from PPFA's most recent annual report, the STI services offered by Planned Parenthood avert, in a year, approximately[128] 70-510 cases of HIV[129] and 56,560-99,770 other STIs, and, in

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Even a relatively few number of HIV/AIDS cases averted results in substantial savings. In 2021, the average Medicaid spending per enrollee was $7,085. *Medicaid Spending per Enrollee (Full or Partial Benefit) by Enrollment Group*, Kaiser Family Foundation (2021), https://www.kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. In 2022, the federal government spent an estimated $13 billion on Medicaid services for people with HIV. *Medicaid and People with HIV*, Kaiser Family Foundation (Mar. 27, 2023), https://www.kff.org/hivaids/issue-brief/medicaid-and-people-with-hiv/.

126 Planned Parenthood Federation of America, *A Force for Hope: Planned Parenthood Annual Report 2023-2024*, *supra* note 14, at 23.

127 *Health Benefits and Cost Savings of Publicly Funded Family Planning*, Guttmacher Data Center, https://data.guttmacher.org/calculator (last visited July 2, 2025).

128 The tool provided by Guttmacher requires inputting a state where the service is provided. California data was used as a case study (as it represents one of the largest states by population and numbers of Planned Parenthood health centers) for calculating the potential outcomes among all of the following examples.

129 A range is provided because the estimated health outcomes depend on whether HIV tests were provided to male or female clients, which was not specified in PPFA's report. The result of 70 cases of HIV assumes all tests were administered to women; the result of 510 cases assumes all tests were administered to men.

turn, many PID cases, ectopic pregnancies, and infertility cases.[130] In Massachusetts, testing services provided by Planned Parenthood prevented 920-1,930 cases of chlamydia and other STIs, and resulted in a gross cost savings of $530,540-$545,090 to the Commonwealth.

79. Were Planned Parenthood Members' ability to provide STI-related services eliminated or reduced, the effect on public health would be significant and adverse.[131] In general, patients who contract STIs suffer adverse reproductive health outcomes.[132] STIs are often asymptomatic[133] but can result in PID, a major cause of infertility, ectopic pregnancy, and chronic pelvic pain.[134] Syphilis and gonococcal infections also facilitate the transmission of HIV infections.[135]

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[130] The tool provided by Guttmacher is limited in the type of STI tests that can be entered and the type of STIs it indicates were averted. This range assumes that all STI tests provided by Planned Parenthood health centers were for chlamydia and reflects the number of chlamydia cases likely averted were that assumption true. The low end of the range assumes all tests were provided to only women; the high end assumes all tests were provided to only men.

[131] For example, a 2022 study on the effect of closures of publicly funded family planning health centers on gonorrhea and chlamydia diagnoses in Iowa found that counties with closures had significantly larger increases in gonorrhea rates, and smaller, non-statistically significant increase in chlamydia rates, compared to counties without closures. Megan Srinivas et al., *Sexually Transmitted Infection Rates and Closure of Family Planning Clinics Because of Abortion Restrictions in Iowa*, 5 JAMA Network Open 10 (2022).

[132] *See* David Friedel & Suzanne Lavoie, *Epidemiology and Trends in Sexually Transmitted Infections*, *in* Public Health & Preventive Medicine 155, 159 (Wallace et al., eds., 2008).

[133] Jerusha Barton et al., *Sexually Transmitted Disease Surveillance 2015*, CDC, 6, 43, 54, 55 (Oct. 2016), https://stacks.cdc.gov/view/cdc/41806.

[134] *About Pelvic Inflammatory Disease (PID)*, CDC (Dec. 13, 2023) https://www.cdc.gov/pid/about/; Kristen Kreisel et al., *Prevalence of Pelvic Inflammatory Disease in Sexually Experienced Women of Reproductive Age—United States 2013-2014*, 66 Morbidity & Mortality Wkly Rpt. 80, 80 (2017). Approximately 10-20% of women with chlamydia or gonorrhea may develop PID without adequate treatment. Barton et al., *supra* note 133, at 54.

[135] Barton et al., *supra* note 133, at 6, 17, 31.

80. In rare, but serious, cases, pregnant people infected with chlamydia can pass the infection to their infants during delivery, potentially resulting in ophthalmia neonatorum, which can lead to blindness and pneumonia.[136] Untreated syphilis infections in pregnant people, though rare, can cause significant complications, including fetal death in up to 40% of pregnant people or preterm birth.[137] It can lead to infection of the fetus in 80% of cases, which can result in both physical and mental developmental disabilities.[138]

81. The increased incidence of STIs is likely to disproportionately affect patients with low incomes and patients of color. For example, prevalence of gonorrhea, syphilis, and chlamydia is highly dependent on the geographic area and sociodemographic factors, with increased rates occurring among Hispanic and African American populations, and individuals with lower incomes.[139]

C. Other Negative Health Outcomes Will Likely Result from Decreased Access to Planned Parenthood

82. Restricting or eliminating access to Planned Parenthood health care clinics and services will negatively affect more than just the reproductive health issues described above (the increase in unintended pregnancies and the increased rate of STIs). Family planning providers, like Planned Parenthood Members, often serve as a source of primary care services for patients.[140] For many people, reproductive health services are the only health services that they seek during

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136 *Id.* at 6.

137 *Id.* at 31.

138 *Id.* at 31, 54.

139 *Id.* at 1, 2, 18, 54, 69, 70-75.

140 VandeVusse et al., *supra* note 21, at 2.

their reproductive health years.[141] Accordingly, many young people and people with low incomes consider family planning centers to be their usual sources of medical care and their entry points into the health care system.[142]

83. A typical wellness visit at a Planned Parenthood health center may include a regular physical exam (e.g., height, weight, and blood pressure), vaccinations including for HPV, reproductive health services (e.g., birth control, STD screening), pelvic exams, Pap tests, and breast examinations.[143]

84. Such visits can detect important health concerns, like cancer. In its most recent annual report, PPFA reported that its Members provided 426,268 cancer screenings and other diagnostic procedures, resulting in early detection of cancer or abnormalities. These screenings included 191,197 breast exams and 173,397 Pap tests.[144]

85. Services related to family planning, like provision of contraceptives, can have broader health benefits for patients. For example, a decrease in access to contraception may cause patients to lose access to the other health benefits of hormonal contraception, such as treatment of

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[141] Frost et al., *Specialized Family Planning Clinics in the United States*, *supra* note 85, at 522.

[142] Rachel Benson Gold et al., *Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System*, Guttmacher Inst., 16 (Feb. 2009), https://www.guttmacher.org/report/next-steps-americas-family-planning-program-leveraging-potential-medicaid-and-title-x.

[143] *Wellness Visit*, https://www.plannedparenthood.org/learn/health-and-wellness/wellness-visit (last visited July 2, 2025).

[144] *A Force for Hope, Planned Parenthood Annual Report 2023-2024*, *supra* note 14, at 23.

menstrual disorders, acne, hirsutism, or pelvic pain; reduced risk of various cancers; and protection against PID and some benign breast diseases.[145]

86. A study of publicly funded family planning providers in California—approximately half of which were Planned Parenthood Members—found that most new clients received an initial health assessment; 83% received a blood pressure test; more than 70% were screened for alcohol, tobacco and drug use; more than 60% were asked whether they had high blood pressure or diabetes; about half were asked whether they had gained, lost, or been maintaining their weight; and more than half were asked about interpersonal violence in the past 12 months.[146]

D. State-Level Defunding Experiences Demonstrate the Negative Effect Restricting Access to Planned Parenthood Members Has on Health Outcomes

87. The public health risks described above are far from theoretical. In recent years, several states have enacted laws that restrict funding for Planned Parenthood health centers specifically, and for family planning efforts generally. The health outcomes following those restrictions have demonstrated both that Planned Parenthood health centers play an essential role in reproductive and preventive health care and that the presence of other providers is insufficient to curb the public health risks of eliminating Planned Parenthood.

88. When States have excluded Planned Parenthood Members from public health funding they saw overall declines in patient access, and corresponding increases in the negative impacts caused by decreased access.

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[145] ACOG Practice Bulletin No. 110, *Noncontraceptive Uses of Hormonal Contraceptives*, 115 Obstetrics & Gynecology 206 (listing non-contraceptive benefits); Adolf E. Schindler, *Non-Contraceptive Benefits of Oral Hormonal Contraceptives*, 11 Int'l J. Endocrinology & Metabolism 41, 45-46 (2013).

[146] M. Antonia Biggs et al., *Findings from the 2012 Family PACT Client Exit Interviews*, Bixby Center for Global Reproductive Health, University of California, San Francisco (2014).

1. Kansas & Tennessee

89. When Kansas excluded the Planned Parenthood Member from Title X funding, the number of people accessing Title X services decreased by more than 14,000 between 2011 and 2015, and some areas were left without a single family planning provider.[147] After Tennessee excluded the local Planned Parenthood Member from Title X funding in 2011, Shelby County reported declines in family planning services patients by 93%.[148]

2. Iowa

90. And after Iowa defunded the local Planned Parenthood Member in 2017, four Planned Parenthood health centers were forced to close and there was an 86% reported decline in the provision of services.[149] Between 2016 and 2018, the number of people being served under the state's Family Planning Program decreased from 10,817 to 1,502.[150] Further, 74 of the 695 listed providers in the state-funded family planning program did not offer contraception.[151]

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147 Roxanne Hegeman, *Feds push back on states targeting Planned Parenthood funds*, Associated Press (Sep. 24, 2016), https://apnews.com/domestic-news-domestic-news-general-news-03c09aa8420a4bce98a413449129d2f8.

148 Tara Culp-Ressler, *Defunding Planned Parenthood Caused Women's Services To Drop By 93% in Tennessee County*, ThinkProgress (Sep. 6, 2012), https://thinkprogress.org/defunding-planned-parenthood-caused-womens-services-to-drop-by-93-percent-in-tennessee-county-bc0562be7a7f/.

149 Michaela Ramm, *Iowa's family planning service use plummets 85% after switch to new program*, The Gazette (Dec. 10, 2019), https://www.thegazette.com/health-care-medicine/iowas-family-planning-service-use-plummets-85-percent-after-switch-to-new-program/.

150 *Id.*

151 Tony Leys and Barbara Rodriguez, *State family planning services decline 73% in fiscal year as $2.5M goes unspent*, Des Moines Register (Oct. 18, 2018), https://www.desmoinesregister.com/story/news/health/2018/10/18/iowa-health-care-family-planning-contraception-services-planned-parenthood-abortion-medicaid/1660873002/.

91. Patients in Iowa experienced significant disruptions to care as a result of the Iowa defunding.[152] The share of patients who had not recently received contraceptive care nearly doubled, from 32% to 62%.[153] Further, the share of patients not using any contraceptive method increased from 9% to 15%.[154] Patients also reported reduced hours and provider availability as barriers to accessing care.[155] Up to 176,550 women in Iowa now live in counties that lack reasonable access to contraceptive care; almost 50,000 women live in counties without a single health care provider that offers a full range of contraceptive methods.[156] Rates of gonorrhea, chlamydia, and syphilis spiked in the year after the defunding.[157]

92. A 2022 longitudinal study found Iowa patients paid more for care and experienced longer wait times or reduced clinical hours, as a result.[158]

3. Indiana

93. As an example of the likely increase in incidences of STIs, a Planned Parenthood facility close to Scott County, a small, rural community in Indiana, closed in 2013 due to cuts to

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152 *The Harm of Defunding Planned Parenthood Health Centers*, Planned Parenthood Federation of America, at 5 (Apr. 2025) https://www.plannedparenthood.org/uploads/filer_public/60/22/6022aa2f-caed-4946-966f-7186b9751e3c/defunding_state_cases_20_pdf.pdf?_gl=1*1acswxo*_gcl_au*OTIzNTI5MjYzLjE3NTA4NjE0ODk.*_ga*MjIyMjU2NjExLjE3NTA4NjE0OTA.*_ga_ENXC8KHJL8*czE3NTA4NjM5MTkkbzIkZzAkdDE3NTA4NjM5MjMkajU2JGwwJGgxMDAzMjgzMTAx.

153 *Id.* at 6.

154 *Id.*

155 *Id.*

156 *Id.*

157 *Id.*

158 Lori Frohwirth et al., *Access to Preferred Contraceptive Strategies in Iowa: A Longitudinal Qualitative Study of Effects of Shifts in Policy and Healthcare Contexts*, 33 J. Health Care for the Poor & Underserved 3 (2022).

public health funding.[159] There was no free HIV testing available in the community after that closure.[160] From 2014 to 2015, syringe-sharing in connection with injections of opioids led to an outbreak of 181 cases of HIV in the area.[161] Nearly 90% of these cases occurred in Scott County, where only five infections had been identified between 2004-2013.[162] The outbreak has been described as "one of the largest and most rapid HIV outbreaks the country has ever seen."[163] Researchers observed that "[r]esources related to the prevention and treatment of HIV did not exist in this community before the outbreak, and, as in many rural communities, access to basic health care, substance-abuse treatment, and HIV prevention services was limited."[164]

4. Texas

94. The devastating effects of excluding Planned Parenthood health centers from family planning services has been well documented in Texas. Since 2011, Texas state lawmakers have continuously revoked funding from Planned Parenthood health centers and other providers

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159 Hal C. Lawrence & Debra L. Ness, *Planned Parenthood Provides Essential Services that Improve Women's Health*, 166 Annals of Internal Medicine 443, 443 (2017); Philip J. Peters et al., *HIV Infection Linked to Injection Use of Oxymorphone in Indiana, 2014-2015*, 375 N. Eng. J. Med. 229, 230 (2016).

160 Peters et al., *supra* note 159, at 230.

161 *Id.* at 231, 233.

162 *Id.*

163 Lawrence & Ness, *supra* note 159, at 443; *See also,* Laura Bassett, *Indiana Shut Down Its Rural Planned Parenthood Clinics And Got An HIV Outbreak*, HuffPost (Mar. 31, 2015), https://www.huffpost.com/entry/indiana-planned-parenthood_n_6977232 (noting HIV outbreak followed Indiana's exclusion of Planned Parenthood health centers from CDC funding).

164 Peters et al., *supra* note 159, at 237.

who offered abortions.[165] These efforts have decimated access to reproductive care in rural communities like the El Paso and Hidalgo service areas,[166] increased unintended pregnancies,[167] and led to lower quality of care for family planning for Texans with low incomes.[168]

95. This conclusion is supported by analyses that the George Washington University, Milken Institute School of Public Health conducted in 2012 regarding the potential effects of a Texas policy that prohibited Planned Parenthood centers from participating in the Texas Women's Health Program ("WHP"). This program is particularly relevant to this declaration as it helped fund family planning services for patients with low incomes using a combination of federal and state funds (like Medicaid).[169] Planned Parenthood Members' exclusion from the WHP was thus a "controlled experiment" of sorts regarding the effect of excluding Planned Parenthood Members from the federal Medicaid program. As a result of the defunding, these organizations, including Planned Parenthood Members, were forced to reduce their hours and charge uninsured women fees

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165 *See, e.g.*, Emily Ramshaw, *Lawmakers Could Restore Family Planning Funds*, The Texas Tribune (Dec. 7, 2012), https://www.texastribune.org/2012/12/07/lawmakers-could-restore-family-planning-funds/#:~:text=When%20state%20lawmakers%20passed%20a,%2C%20in%20some%20cases%2C%20; Amanda J. Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 N. Eng. J. Med. 853, 858 (2016); Shannon Najmabadi, *Judge rejects bid by Planned Parenthood to stay in Medicaid, affecting health care for thousands of low-income Texans*, The Texas Tribune (Mar. 10, 2012), https://www.texastribune.org/2021/03/10/planned-parenthood-medicaid-texas/.

166 *Healthy Texas Women Section 1115 Demonstration Waiver Evaluation: Interim Report*, UT Health Houston School of Public Health Center for Health Care Data, 43 (Dec. 2023), https://www.hhs.texas.gov/sites/default/files/documents/htw-1115-demonstration-interim-evaluation-report.pdf.

167 Stevenson et al., *supra* note 165, at 858.

168 Shetal Vohra-Gupta et al., *Evidence-based family planning services among publicly funded providers in Texas*, 22 BMC Health Services 1498, 1499 (Nov. 2022), [doi: 10.1186/s12913-022-08889-0].

169 Ku et al., *supra* note 74.

for health services that had previously been free or lower cost, making it more difficult or impossible for those patients to get care.[170]

96. The consequences of this WHP defunding were dire: within two years, nearly 45,000 fewer women received care through the program and nearly 30,000 fewer patients received birth control, cancer screenings, and other preventative care.[171] Within five years, 41% fewer women received contraceptive care through the program.[172] And only 6% of patients were told they could receive their chosen contraceptive method in a single visit, which is considered best practice.[173]

97. Before the exclusion, Planned Parenthood health centers served nearly 52,000 (49%) WHP patients, while FQHCs served just over 10,000 WHP patients (10%), indicating that other publicly funded health centers would have to increase their capacity five-fold to serve Planned Parenthood's WHP patients.[174] In 2013, after the state began running an entirely state-

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[170] Joseph E. Potter & Karri White, *Defunding Planned Parenthood was a disaster in Texas. Congress shouldn't do it nationally*, Wash. Post (Feb. 7, 2017), https://www.washingtonpost.com/posteverything/wp/2017/02/07/defunding-planned-parenthood-was-a-disaster-in-texas-congress-shouldnt-do-it-nationally/.

[171] Molly Redden, *Texas seeks unprecedented federal money to defund Planned Parenthood*, The Guardian (May 11, 2017), https://www.theguardian.com/us-news/2017/may/11/texas-federal-financing-defund-planned-parenthood-healthcare#:~:text=A%20report%20commissioned%20by%20the%20state%20of%20Texas%20found%20that%20its%20state%2Dfunded%20women%E2%80%99s%20health%20program%20served%2030%2C000%20fewer%20women%20than%20the%20old%20program.

[172] *Excluding Planned Parenthood has been Terrible for Texas Women*, Every Texan, at 7 (Aug. 2017) https://everytexan.org/images/HW_2017_08_PlannedParenthoodExclusion.pdf.

[173] Whitfield et al., *supra* note 92, at 2.

[174] Peter Shin et al., *An Early Assessment of the Potential Impact of Texas' "Affiliation" Regulation on Access to Care for Low-income Women*. Geiger Gibson/RCHN Community Health Foundation Research Collaborative: Policy Research Brief No. 29 (revised May 4, 2012), https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1047&context=sphhs_policy_ggrchn.

funded women's health program that excluded Planned Parenthood Members, enrollment in WHP dropped precipitously. A 2015 Texas Health and Human Services report found that enrollment in WHP fell by 9% from FY2011 to FY2013, with enrollment drops particularly severe in the High Plains (38%) and West Texas (41%)—regions where alternative providers were already scarce.[175] Service utilization decreased by 26% state-wide in this time period; the largest drops were seen in the West Texas (64%), the High Plains (53%), and Central Texas (42%) regions.[176]

98. Unintended pregnancies also increased due to defunding Planned Parenthood Members in Texas. A study in the New England Journal of Medicine compared rates of contraceptive use and Medicaid-covered births using data from medical, pharmacy, and childbirth claims from counties with Planned Parenthood clinics to counties without them from 2011-2014.[177] The exclusion of Planned Parenthood from the WHP was significantly associated with a 35% decline in women using the most effective methods of family planning and a 27% increase in births among women who had been using an injectable prior to Texas's restrictions.[178]

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[175] *Texas Women's Health Program: Savings and Performance Reporting* (2015), Texas Health and Human Services Commission, https://docs.house.gov/meetings/IF/IF14/20150917/103957/HHRG-114-IF14-20150917-SD107.pdf.

[176] *Id.* at 3.

[177] Stevenson et al., *supra* note 165, at 853-60.

[178] *Id.* at 858. *See also* Kari White et al., *The Impact of Reproductive Health Legislation on Family Planning Clinic Services in Texas*, 105 Am. J. Pub. Health 851, 851 (2015). White and colleagues describe how, in 2011, prior to Planned Parenthood's outright exclusion from Texas's publicly funded family planning program, Texas substantially cut public funding for family planning providers and imposed a priority system of reimbursement for services that placed certain providers, including Planned Parenthood, at the bottom of the hierarchy. In the year following those cuts, 54% fewer clients received publicly funded family planning services. *Id.* at 855. Providers suspected that clients stopped seeking reproductive health care. *Id.* at 856.

99. The same study showed that the number of claims submitted for LARC contraceptives in counties where Planned Parenthood Members were previously located decreased sharply.[179] Researchers concluded that their analyses indicated that Planned Parenthood Members' exclusion adversely affected low-income women in Texas "by reducing the provision of highly effective methods of contraception, interrupting contraceptive continuation, and increasing the rate of childbirth covered by Medicaid."[180] Some observers attributed the decrease in LARCs to providers with limited funds offering patients oral contraceptives rather than their preferred LARC option, impinging upon patients' ability to select the method of contraception that is most tailored to their needs.[181] Providers were placed in a position of trying to provide care to more patients with limited resources, and thus selected to offer lower cost oral contraception to meet these needs.[182]

100. However, rates of continuation of non-LARC contraception methods, such as oral contraceptives, also decreased in counties where Planned Parenthood Members were previously located.[183] Patients who used oral contraceptives received fewer refills up front, "a practice that has been shown to result in lower rates of continuation with the method and that may increase the likelihood of unintended pregnancy—and therefore that of abortion."[184] In a separate study, patients were contacted who had obtained injectable birth control from a Planned Parenthood

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179 Stevenson et al., *supra* note 165, at 856-58.

180 *Id.* at 858-59.

181 Kari White et al., *Cutting Family Planning in Texas*, 367 N. Eng. J. Med. 1179, 1180 (Sept. 2012) [doi: 10.1056/NEJMp1207920].

182 *Id.*

183 Stevenson et al., *supra* note 165, at 856-58.

184 White et al., *Cutting Family Planning*, *supra* note 181, at 1180.

health center prior to its exclusion.[185] As a result of Planned Parenthood's exclusion, approximately one in five women interviewed missed a dose of their injectable birth control.[186] The most commonly cited reasons for missing a dose were difficulty finding a provider, cost, and trouble getting an appointment.[187]

101. Because fewer women were receiving birth control counseling and services, this contributed to a significant 27% increase in Medicaid-covered births within 18 months for patients that had been previously using injectable contraceptives.[188] Analysis by researchers from the Centers for Disease Control and Prevention found that the maternal mortality rate in Texas doubled from 2011 to 2012.[189] While the analysis could not identify the cause of the sudden increase, the authors speculated that one possible reason was the change made under Texas' WHP policies.[190]

102. In 2020, President Trump's first administration approved federal funding for a new version of WHP called Health Texas Women ("HTW"), allowing the continued exclusion of Planned Parenthood Members from the program.[191] Despite having more funding, the federally funded HTW program has still been unable to meet the needs of Texans. This defunding continues

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185 C. Junda Woo et al., *Women's Experiences After Planned Parenthood's Exclusion from a Family Planning Program in Texas*, 93 Contraception 298 (2016).

186 *Id.* at 300.

187 *Id*.

188 Stevenson et al., *supra* note 165, at 853.

189 Marian F. MacDorman et al., *Trends in Texas Maternal Mortality by Maternal Age, Race/Ethnicity, and Cause of Death, 2006-2015*, 45(2) Birth 169, Fig 1, (Jan. 4, 2018) [doi: 10.1111/birt.12330].

190 *Id.*; *see also* Marian F. MacDorman et al., *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues*, 128(3) Obstetrics and Gynecology, 1-10 (Sept. 2016), [doi: 10.1097/AOG.0000000000001556].

191 *The Harm of Defunding Planned Parenthood Health Centers*, *supra* note 152, at 3-4.

to lead to drastic results, particularly for Latinas in the state. In the four counties encompassing the Rio Grande Valley—where 92% of residents are Latino—one in four clinics were forced to close after the 2011 cuts.[192] The Rio Grande Valley has one of the highest cervical cancer rates in the country, despite the fact that cervical cancer is highly preventable and treatable when patients can get access to HPV vaccines, timely screenings, and care for cervical abnormalities.[193] More broadly, Latinas in Texas have among the highest rates of cervical cancer in the United States.[194]

103. The December 2023 HTW Evaluation Interim Report indicates that only half of Texas Medicaid family planning providers participated in HTW.[195] It also shows that the new federal funding did not help to increase the number of family planning providers in the program, and that primary care providers have not been able to make up for the lack of access to family planning providers.[196] The primary care providers in the program see fewer patients and are less likely to follow evidence-based practices than Planned Parenthood Members.[197] Rural regions in Texas suffer most from lack of access to providers.[198]

104. In 2021, Texas blocked Medicaid enrollees from getting care at Planned Parenthood Member centers altogether by removing them as providers in the entire state Medicaid program, further eroding access to sexual and reproductive health care in the state. Researchers conducting

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192 *Id.* at 4.

193 *Id*.

194 *Id*.

195 *Healthy Texas Women Section 1115 Demonstration Waiver Evaluation*, *supra* note 166, at 82-83, Table 26.

196 *Id.* at 78, Table 24.

197 *Id.* at 33-40, Fig. 9.

198 *Id.* at 42.

a secret shopper study found that only 6% of callers were informed that they could get contraception with just one visit to a provider, despite the fact that this is the medically-accepted standard of care and that it reduces the barriers patients must overcome to obtain birth control.[199] The study also found other barriers to obtaining contraception for Medicaid patients, including lack of availability for requested methods and long wait times for the next available appointment.[200] Another study found that patients of Planned Parenthood Members in Texas found it difficult to connect with other providers and to get evidence-based care, leading to lower quality care, delayed or foregone care, and emotional distress.[201]

105. A 2023 report by the University of Texas Health Science Center at Houston's (UTHealth) School of Public Health Center for Health Care Data (CHCD), which evaluated the developing impact of the Section 1115 Medicaid Waiver, found that access to care dropped significantly between 2020 and 2023.[202] Network adequacy rates for micro counties in the Hidalgo service area remained low and percentage of Medicaid enrollees decreased precipitously from 49% to 27%.[203] Rural counties in the El Paso service area had a network adequacy rate of 0, and the enrollee count also dropped from 35 to 3.[204] Moreover, of the 5,400 remaining providers for family planning, nearly half saw no patients in 2017 and another 700 saw only one patient.[205]

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199 Whitfield et al., *supra* note 92, at 2, 3.

200 *Id.* at 3.

201 Anna Chatillon et al., *supra* note 75.

202 *Healthy Texas Women Section 1115 Demonstration Waiver Evaluation*, *supra* note 166, at 43.

203 *Id.*

204 *Id.*

205 *Id.*

106. An analysis conducted by March of Dimes, a nonprofit organization committed to ending preventable maternal health risks and death, found that "women in Texas have a very high vulnerability to adverse outcomes due to [lack of] the availability of reproductive healthcare services."[206] In 2023, 47% of counties in Texas were maternity care deserts and had no maternity care centers or obstetricians.[207] Patients in these counties who seek maternity care traveled an average of 30 miles to find a doctor, with some required to travel up to 70.5 miles to find the nearest birthing hospitals.[208]

107. There is no reason to believe that the effect of removing Planned Parenthood Members from the federal Medicaid program would be any less pronounced than the observed effects of excluding local Planned Parenthood Members from WHP in Texas, or from other states, such as Kansas, Tennessee, Indiana, and Iowa. Instead, it is reasonable to believe that the dramatic decline in use of effective contraception—and resulting increase in Medicaid-covered childbirth—will be replicated on a national scale.

IV. CONCLUSION

108. For the foregoing reasons, Planned Parenthood health centers provide a unique contribution to the health and wellbeing of individuals and families across the United States, and it is my opinion that Section 71113 will have serious and adverse consequences for patients, their families, and the public's health, as well as the societal burden.

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206 Lucas J. Fontenot et al., *Where You Live Matters: Maternity Care in Texas*, March of Dimes, 2 (2023), https://www.marchofdimes.org/peristats/reports/texas/maternity-care-deserts.

207 *Id.*

208 *Id.*

I declare under penalty of perjury that the foregoing is true and correct. Executed on July 7 , 2025.

Claire D. Brindis

July 7, 2025
Date

EXHIBIT A

Prepared: July 2, 2025

University of California, San Francisco

CURRICULUM VITAE

Name: Claire D Brindis, DrPH, MPH

Position: Emerita Director,Philip R. Lee Institute for Health Policy Studies
Distinguished Professor Emerita of Pediatrics and Health Policy (on recall),
UCSF Edward A. Dickson Emeritus Professorship Award (2022-2024)
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EDUCATION

1968 - 1972	University of California, Los Angeles	B.A.	Sociology, Cum Laude
1972 - 1973	University of California, Los Angeles	M.P.H.	Public Health
1977 - 1982	University of California, Berkeley	Dr. PH	Public Health/Behavioral Sciences

PRINCIPAL POSITIONS HELD

1974 - 1977	Emory University	Assistant Professor	School of Allied Health
1982 - 1983	San Francisco State University	Assistant Professor	San Francisco State Health Education
1982 - 1987	University of California, San Francisco	Senior Research Associate	Institute for Health Policy Studies
1987 - 1992	University of California, San Francisco	Assistant Adjunct Professor	Institute for Health Policy Studies
1992 - 1998	University of California, San Francisco	Associate Adjunct Professor	Institute for Health Policy Studies

1998 - 1998	University of California, San Diego	Visiting Professorship	Iris F. Litt Society for Adolescent Medicine/Organon Adolescent Health Research, Sponsored by Society for Adolescent Medicine
1998 - 2000	University of California, San Francisco	Adjunct Professor	Pediatrics and Institute for Health Policy Studies
2000 - 2009	University of California, San Francisco	Professor, In-Residence	Philip R. Lee Institute for Health Policy Studies/Joint Appointment with Dept of Pediatrics & Obstetrics, Gynecology and Reproductive Health Sciences
2002 - 2002	Children's National Medical Center	Visiting Professorship	Robert S. Rixse Memorial Lecture, Washington, DC
2005 - 2005	University of Texas, Houston	Visiting Professorship	Morris Blum Memorial Lecture, Pediatric Grand Rounds University of Minnesota Adolescent Health Leadership
2006 - 2006	Howard University, and Johns Hopkins University	Visiting Professorship	The DC-Baltimore Research Center on Child Health Disparities: a consortium of the Department of Health, the Children's National Medical Center
2007 - 2007	University of New Mexico	Visiting Professorship	Center for Latinos and Health Disparity

2009 – present	University of California, San Francisco	Distinguished Professor	Philip R. Lee Institute for Health Policy Studies/Joint Appointment with Dept of Pediatrics & Obstetrics, Gynecology and Reproductive Health Sciences
2022-2024	University of California, San Francisco		UCSF Edward A. Dickson Emeritus Professorship Award
2014 - 2020	University of California, Hastings	Adjunct Professor of Law	UC Hastings College of the Law
2014 - present	University of California, San Francisco	Affiliated Faculty	Institute of Global Health Sciences
2016 – present	University of California, San Francisco	Affiliated Faculty	Bakar Institute for Computational Health Sciences
2016 - 2016	Pennsylvania State University	Visiting Professorship	Division of Health Services and Behavioral Research
2017 - present	University of California, Los Angeles	Affiliated Faculty	UCLA School of Public Health, Center for Health Policy
2021 – present	University of California, San Francisco	Affiliated Faculty and SeniorAdvisor	University of California Center for Climate, Health, and Equity
2022 – present	University of California, San Francisco	Faculty Advisor; Evaluator	UCSF ARCHES (Advancing the Research Careers for Historically Excluded Scholars) Program

OTHER POSITIONS HELD CONCURRENTLY

1983 - 1999	University of California, San Francisco	Co-Director	Center for Reproductive Health Policy Research, Institute for Health Policy Studies,
1983 - 2005	University of California, San Francisco	Director	Hewlett Fellowship in Reproductive Health Policy, Institute for Health Policy Studies
1993 - 2014	University of California, San Francisco	Executive Director/Co-Principal Investigator	National Adolescent Health Information and Innovation Center; Department of Pediatrics and Institute for Health Policy Studies
1997 - 2014	University of California, San Francisco	Associate Director/Co-Principal Investigator, Public Policy Analysis Center	Department of Pediatrics and Institute for Health Policy Studies
1998 - present	University of California, San Francisco	Co-Director	Adolescent and Young Adult Health National Resource Center, Division of Adolescent Medicine, Department of Pediatrics
1999 - present	University of California, San Francisco	Associate Director/Co-Principal Investigator	Division of Adolescent Medicine, Department of Pediatrics

1999 - present	University of California, San Francisco	Director and Founding Director and Senior Scholar, 2018-current	Bixby Center for Global Reproductive Health, Obstetrics, Gynecology and Reproductive Sciences and Institute for Health Policy Studies
2002 - 2020	University of California, San Francisco	Core Faculty	Center for Social Disparities in Health; Dept. Family and Community Medicine
2005 - 2007	University of California, San Francisco	Associate Director	Institute for Health Policy Studies
2006 - 2007	University of California, San Francisco	Acting Director	Philip R. Lee Institute for Health Policy Studies
2007 - 2008	University of California, San Francisco	Interim Director	Philip R. Lee Institute for Health Policy Studies
2008 - 2020	University of California, San Francisco	Director	Philip R. Lee Institute for Health Policy Studies
2016 – present	University of California, Berkeley	Affiliated Faculty	Berkeley Ph.D. Program in Health Policy

HONORS AND AWARDS

1988	Special Recognition Award	California Alliance Concerned with School Age Parents
1991	Community Leadership Award	National Family Planning and Reproductive Health Association, Washington, D.C.
1994	Integrity Award	Office of Inspector General, Office of Evaluation and Inspections, U.S. Department of Health, Human Services

2000	Mark Pearlman Outstanding Service Award	California Child, Youth and Family Coalition
2000	Beverlee A. Meyer Award in Excellence	California Department of Health Services
2000	Distinguished Service to the Public and the State of California	California State Senate Resolution, State of California
2001	Collaborative Award Winner, Special Recognition Award	Maternal and Child Health Branch, California Department of Health Services
2001	John C. MacQueen Lecture Award	Association of Maternal and Child Health Programs
2001	Women Faculty Recognition Award	University of California, San Francisco
2003	Champions of Diversity	University of California, San Francisco
2004	Executive Leadership in Academic Medicine (ELAM) Program for Women	Fellow-Hedwig van Ameringen
2005	Morris Blum Memorial Lecture, Pediatric Grand Rounds	University of Minnesota
2005	Commendation by Lieutenant Governor Cruz M. Bustamante Honoring Outstanding Research on Adolescent and Women's Health, Education, and Dissemination on These Important Issues, Fresno County Babies First Seminar.	State of California
2005	Directors Award: In Recognition of Contributions Made to the Health of Infants, Mothers, Children, Adolescents & Children with Special Needs	Federal Maternal & Child Health Bureau
2005	Special Election Award	Campaign for Teen Safety
2006	Hilary E.C. Millar Award for Innovative Approaches to Adolescent Health Care	Society for Adolescent Medicine
2006	Champion Award for vision and commitment in creating and sustaining the California Office of Family Planning and the Family PACT Program.	California Family Health Council, Inc

2006	Outstanding Researcher Award in honor of the dedication and leadership in the field of adolescent pregnancy, parenting and prevention.	Healthy Teen Network
2006	Award for service on No on 85 Campaign 'Above and Beyond'	Campaign for Teen Safety
2009	Chancellors Award for the Advancement of Women, 'In Recognition of Outstanding Contributions to the Advancement of Women'	University of California, San Francisco
2009	Telly Award, Bronze Award	Telly Award for Film, 'A Question of Hope', Social Issues Category
2011	Institute of Medicine of the National Academies (IOM) member	Elected Member
2012	Alumni Hall of Fame: Outstanding Contributions to the Field of Public Health	UCLA Fielding School of Public Health
2014	Carl S. Shultz Award for Lifetime Achievement	American Public Health Association: Population, Reproductive, and Sexual Health Section
2016	Lifetime Achievement in Mentoring Award	UCSF Faculty Mentoring Program
2018	75th Anniversary Honoree “In Recognition of 75 Most Influential Public Health Alumni”	UC Berkeley School of Public Health
2018	In Recognition for Outstanding Contribution to the Advancement of Women’s Reproductive Health	Bixby Center for Global Reproductive Health, UCSF
2019	Holly Smith Award for Exceptional Service to the UCSF School of Medicine	University of California, San Francisco
2020	Pioneer Award	School-Based Health Assembly
2020	Martha May Eliot Award in Maternal and Child Health	American Public Health Association

2021	2020 Title V Lifetime Achievement Award	Maternal and Child Health Bureau (MCHB)
2024	Excellence in Maternal, Child, and Adolescent Health Leadership Award	UC Berkeley School of Public Health Department of Maternal, Child, and Adolescence Health

Note: In 2023, the Claire D. Brindis Award for Community Engagement and Service in Health Policy Research was established by the Philip R. Lee Institute for Health Policy Studies at UCSF. This award recognizes UCSF faculty who are engaged in policy-focused research and advocacy which address social, health, and, ethnic, and racial disparities; this research and advocacy serve to improve community wellbeing. Community engagement and service spans a range of fields and topics, including – but not limited to – collaboration with federal, state, or local government agencies, local and community clinics, school systems, and community-based organizations. Additionally, such service may include other community and institutional efforts to advance the health and well-being of historically underserved and excluded populations.The Award recognizes a UCSF faculty member who embodies a commitment to giving voice, representation, and service to historically underserved communities; this advocacy and research in healthcare design inform policymaking in ways which achieve tangible gains in health and well-being.

KEYWORDS/AREAS OF INTEREST

United States healthcare reform, adolescent and child health policy, health disparities, and social determinants of health, adolescent pregnancy and pregnancy prevention, adolescent and young adult health and risk-taking behaviors, reproductive health services for men and women, program evaluation, Latino health, global reproductive health, migration and health, knowledge-transfer.

PROFESSIONAL ACTIVITIES

MEMBERSHIPS

1972 - present	American Public Health Association
1984 - present	Society for Public Health Education
1985 - present	Society for Adolescent Medicine and Health
1985 - present	Society for Health Education
1988 - present	American School-Health Association
1995 - present	National Assembly for School-Based Health Care
2000 - present	AcademyHealth
2005 - present	National Alliance for Hispanic Health
2015 - present	Society of Family Planning

SERVICE TO PROFESSIONAL ORGANIZATIONS

National Academies of Sciences, Engineering, and Medicine/National Research Council

2005-2006	Contributions from the Behavioral & Social Sciences in Reducing and Preventing Teen Motor Crashes Institute of Medicine and the Division of Behavioral and Social Sciences and Education. The National Academies of Sciences, Washington DC.	Member
2020-2025	NRC, Advisory Board, Division of Behavioral and Social Sciences and Education Studies	Member
2012 – 2016	National Academy of Medicine (formerly IOM), Section 1 Health Policy and Health Care Systems Working Groups	Elected Member (Two Terms 3 years each)
2021-2024	Executive Committee of the NAM Council	Vice-Chair (DuringTerm 2)
2018-2024	Council of the National Academy of Medicine	Member
2021-2024	Council of the National Academy of Medicine (NAM)	Member
2021-2023	NASEM (National Academies of Science, Engineering and Medicine), National Research Council (NRC) National	Member
2021-2024	Research Council (NRC), Executive Committee	Member
2023-2024	National Research Council (NRC) Governing Board Budget and Finance Committee	Member
2021-2024	National Research Council (NRC) Governing Board Project Approval Committee	Workshop Planning Committee and
2021-2024	National Research Council (NRC) Governing Board NAM Council Nominating Committee	Workshop Moderator
2018-2023	Committee on Science, Engineering, and Medicine and Public Policy (COSEMPUP), NASEM	Member, Policy, Financing, and
2021-2022	National Academy of Medicine Advancing Maternal Health Equity and Reducing Maternal Morbidity and Mortality. (https://www.nap.edu/download/26307	Metrics Member, Health Systems
2022 - Present	National Academy of Medicine, (NAM) Action Collaborative on Decarbonizing the U.S. Health Sector	Member Planning Committee
2023-2024	National Academy of Medicine (formerly IOM), Section 1 Health Policy and Health Services Working Group	Report Monitor

2023-204	National Academy of Sciences, Cultural Programs of the National Academy of Sciences and the CDC Foundation, Boosting Vaccine Confidence with the Arts	Chair
2023	NASEM: Identification and Prognosis of Low Birth Weight Babies and Disability Determinations	Member
2022-2025	NASEM, Standing Committee on Reproductive Health, Equity and Society	Chair
2024-2025	NASEM and National Research Council (NRC) Governing Board Project Approval Committee	Chair
2025 – Present	Advisory Committee, Division of Social and Behavioral Studies and Education Studies (DBASSE), NRC	Chair
2024- Present	National Academy of Medicine, President Search Committee	Chair

Other Professional Associations and Organizations

1996 - 2022	AcademyHealth	Member, Advocacy Committee
1993 - 1993	American Public Health Association	Annual Program Committee, Section on Family Planning and Reproductive Health
1996 - 2000	National Assembly for School-Based Health Care	Technical Advisory Committee, Survey of School-Based Health Centers
1996 - 2006	National Assembly for School-Based Health Care	Member, Advisory Panel, Center for Evaluation and Quality
1997 - 1997	Society for Adolescent Medicine	Managed Care Ad Hoc Committee

2000 - 2022	AcademyHealth	National Planning Committee for Annual Meeting, Chair, Session at Annual Conference. Elected Member, Board of Directors Secretary, Board of Directors, Chair, Governance Committee, Membership Committee Member
2001 - 2001	Society for Adolescent Medicine	Member, Advocacy Committee
2003 - 2003	American Public Health Association	Program Chair
2004 - 2005	American Public Health Association	Section President
2005 - 2007	American Public Health Association	Chair, Awards Committee, Member, Awards Committee
2005 - 2005	Society for Adolescent Medicine	Research (Standing) Committee
2009 - 2009	Society for Adolescent Medicine	Consultant, Diversity Task Force
2014 - 2019	Public Health Institute	Board Member
2015 - 2020	WestEd Justice & Prevention Research Center	Member, Advisory Board, Virtual Student Health Center Project
2015 - present	Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB)	Member, National Survey of Children's Health (NSCH) Technical Expert Panel (TEP)

2017 - present	Public Health Institute	Advisory Council, Initiative for Multipurpose Prevention Technologies (IMPT)
2018 - 2019	AcademyHealth, Adolescents and Children Together for Health (ACT for Health)	Member, National Advisory Panel
2019 – present	Vanderbilt University Medical Center (VUMC)	Biomedical Science Advisory Board
2022- present	Health Affairs Scholar *Emerging & Global Health Policy Journal*	External Advisory Board
2023- present	Social Policies for Health Equity Research (SPHERE) Center, Harvard School of Public Health	National Advisory Board Member
2023-present	AcademyHealth Assessing the Full Impact of the Dobbs'Decision – Working Group	Member

SERVICE TO PROFESSIONAL PUBLICATIONS

1999 - present	Editorial Board, Journal of Adolescent Health
1991 - 2018	Hispanic Health Care International; Editorial Review Board, Health Promotion Practice
1999 - 2018	Health Promotion Practice, Editorial Board
1999 - present	Journal of the American Public Health Association
1999 - present	Journal of the American Medical Association
1999 - present	Archives of Pediatrics and Adolescent Medicine
1999 - 2020	Family Planning Perspectives
1999 - 2020	Perspectives on Sexual and Reproductive Health
1999 - 2020	American Journal of Preventive Medicine, Guest Editor (Long-Acting Reversible Contraceptive Methods in the Developing Word)
1999 - present	Maternal and Child Health Journal, Editorial Board

2017 - 2017	Maternal and Child Health Journal, Guest Editor (Long-Acting Reversible Contraceptive Methods in the Developing World, September, 2017)
2017 - 2017	Journal of Adolescent Health, Guest Editor (Special Supplement on Teenage Pregnancy Prevention)
2019 – present	Health Services Research Journal - Reviewer
2022 - present	Health Affairs Scholar, External Advisory Board

INVITED PRESENTATIONS - INTERNATIONAL

2005	Canadian Evaluation Society and American Evaluation Association, Toronto, Canada,	Keynote address
2008	Binational Conference Defining a Research Agenda on Migration and Health: The Voice of the Community. University of California	Invited Talk
2009	Binational Conference: IX Semana Binacional de Salud / Ninth Annual Binational Policy Forum on Migration and Health Santa Fe, NM	Plenary Talk
2010	The 21st Scientific Conference of the Saudi Heart Association. Riyadh, Saudi Arabia	Two invited talks
2010	Institut Jantung Negara (National Heart Institute), Kuala Lampur, Malaysia	Two invited talks
2011	Egyptian Society of Cardiology: Adolescent obesity, Systems Change, Pediatric Congenital Health Disease. Alexandria, Eygpt	Three invited talks
2011	Mexican Society of Cardiology Annual Meeting: Adolescent obesity. Puerta Vallerta, Mexico	Invited talk in Spanish
2012	Societatea Romana De Cardiologie. National Congress of Cardiology Annual Meeting. Bucharest, Romania. 2012. (Childhood and Adolescent Obesity and the Role of Comprehensive Prevention Approaches)	Invited Talk
2012	Pan American Health Organization (PAHO) What Works in Pregnancy Prevention: Current Scientific Evidence and Lessons Learned. San Salvador, Salvador. August 24, 2012 (Spanish and English).	Invited Talk (English and Spanish)
2014	World Bank: International Interagency Conference: Current Evidence, Lessons Learned and Best Practices in Adolescent Pregnancy Prevention in Latin America and the Caribbean, Managua, Nicaragua 2014.	Invited talk in Spanish
2014	Robert Wood Johnson Foundation, Social Determinants of Migrant's Health Conference: The Burden of the Invisibles: The Experiences of the Deferred Action for Childhood Arrivals Within a Socio-Economic Context. Bellagio, Italy, October 10, 2014	Invited Talk

2016	University of Ottawa, Building Health Systems and Health Equity for Populations Affected by Migration. Health Equity Impact Assessment. Ottawa, Canada. May 16-17, 2016.	Invited Talk
2017	Instituto Nacional de Perinatologia, Mexico City, Mexico. Reunion Anual INPer 2017: Salud Sexual y Reproductiva del Adolescente: Impacto Perinatal: Presentation: El Embarazo de Adolescentes en Mexico y en California: Politicas Publicas y Consecuencias Programaticas, April 4, 2017.	Invited Talk
2020	Adolescent Health and Well Being Issues: A Global Perspective. Indian Institute of Public Health. Gandhinagar, India. January 3, 2020.	Invited presentation
2020	Living in Time of Uncertainty: Advancing Women's Health in India. Joint International Conference 16th Annual Scientific Symposium. Ahmedabad, India. January 4, 2020.	Invited presentation & panel discussion

INVITED PRESENTATIONS - NATIONAL (2006-Present)

2006	A Profile of Adolescent Health and Healthcare Needs". National Institute for Health Care Management Foundation; Washington, DC	Keynote address
2006	Future Directions in Adolescent Healthcare Delivery". Society for Research in Adolescent Health, Boston, MA	Keynote address
2006	Teenage Pregnancy Prevention—Trends and Lessons Learned". Society for Adolescent Medicine, Boston, MA	Keynote address
2006	Developing a Career in Health Policy and Advocacy". American Public Health Association Student Assembly, Boston, MA	Invited talk
2006	"Preventing Teenage Pregnancy: Recent Trends and Directions". Contraceptive Technology Annual Meeting, San Francisco, CA	Keynote address
2006	"The Health and Mental Health Needs of Adolescents". Association of Maternal and Child Health Epidemiology, 12th Annual Conference, OMNI Hotel CNN Center, Atlanta, GA	Keynote address
2007	"A Profile of Adolescent Health and Healthcare Utilization". The National Academies. Research Workshop on Adolescent Health Care Services and Systems, Washington, DC	Platform presentation

2007	“Using State Data to Respond to the Health Needs of Adolescents”. Association of Maternal & Child Health Programs Annual Conference, Arlington, VA	Plenary talk
2007	“Health Care Coverage for Adolescents: Where are the Gaps?”. AcademyHealth Meeting, Orlando, FL	Invited talk
2007	“Meeting the Needs of Adolescents: Promising State Directions”. National Conference of State Legislators, Boston, MA	Invited talk
2007	"Responding to the Health Needs of Adolescent Males: Opportunities and Challenges”. The National Campaign to Prevent Teen and Unplanned Pregnancy, Santa Monica, CA	Platform presentation
2007	“Preconception Health and Health Care”. Second National Summit, in collaboration with the Department of Health and Human Services, Centers for Disease Control and Prevention, and the Health Resources and Services Administration, Oakland, CA	Invited talk
2009	“A Health Profile of America’s College Age Students”. American College Health Association. Building Bridges by the Bay: 2009 Annual Meeting, San Francisco, CA	Keynote address
2009	“The Role of Community-Based Organizations in Meeting the Health Needs of Women”. National Institutes of Health, NIH/Office of Research in Women's Health and UCSF Center of Excellence in Women's Health, New Dimensions and Strategies for Women's Health Research, National Conference, San Francisco, CA	Platform
2009	“Evaluating Community Agencies Serving Women: Promising Findings”. Johnson and Johnson Foundation and UCSF Center of Excellence in Women's Health. Fostering Excellence in Women's Health Through Academic - Community Partnerships, Annual Convening, Hotel Kabuki, San Francisco, CA	Invited talk
2010	“Meeting the Health Needs of Adolescents: Future Directions”. GrantMakers in Health Annual Meeting on Health Philanthropy, Charting a Healthy Life Course for Children, Orlando, FL	Invited talk
2010	Using State Profile Data to Develop New Program Strategies”. Association of Maternal & Child Health Programs Annual Conference. National Harbor, MD	Invited panelist

2010	“The Needs of Adolescents and Young Adults – Future Directions”. AcademyHealth Annual Conference, Boston, MA	Invited panel presentation
2010	“Making Healthy People 2020 Come Alive for Promoting Adolescent Health”. 20th Annual CityMatCH Conference. Making Healthy People 2020 Come Alive for Promoting Adolescent Health, Chicago, IL	Invited presentation
2010	"Maternal and Child Health Reform: Looking to the Future". AMCHP Annual Meeting, Washington, DC	Invited speaker
2011	“The Environment of Girl's Health and Next Steps in the Creation of a National Initiative to Improve the Health of Young Women and Girls”. Department of Health and Human Services, Office on Women's Health, Washington, DC	Invited briefing
2011	“Approaches for Supporting Pregnant and Parenting Teens”. Office of Population Affairs Office of Adolescent Pregnancy Programs; Washington, DC	Invited speaker
2011	“Male Adolescent Health: Future Directions”. The 2011 National Conference for Male Family Planning and Reproductive Health Services, San Francisco, CA.	Invited talk
2011	"IUD Summit: US Trends in IUD Use". Des Moines, IA.	Invited speaker
2012	“The Health Needs of Adolescents and Young Adults”. AcademyHealth Annual Research Meeting, Washington, DC.	Invited speaker and panelist
2012	“Lessons Learned in Adolescent Pregnancy Prevention". National Reproductive Health Conference Title X.	Invited speaker
2012	"Evaluation of the Iowa LARC Initiative: Early Research Findings". Policy Briefings, Des Moines, IA.	Invited speaker
2012	“A Profile of Adolescent and Young Adult Health”. 18th Annual Maternal and Child Health Epidemiology (MCH EPI) Conference. learning.mchb.hrsa.gov	Invited speaker and moderator
2012	“The Needs of Adolescents: How Can we Best Respond in an Era of Health Reform?” San Francisco Chapter of the National Association of Pediatric Nurse Practitioners. Stanford University, Stanford, CA.	Invited speaker

2012	"Making Do with Less: The Impact of State Budget Cuts on California's Teen Pregnancy Prevention Programs". American Public Health Association Annual Meeting. San Francisco, CA.	Invited panel presentation.
2012	"Stayin' Alive and Thriving: Exploring Multiple Dimensions of SBHC Sustainability". American Public Health Association Annual Meeting. San Francisco, CA.	Invited panel presentation
2013	"Advancing the Maternal & Child Health Vision. The ACA, Adolescents and Young Adults". AMCHP Annual Conference.	Invited speaker
2013	"Improving the Health, Safety, and Well-being of Young Adults". Institute of Medicine, Washington DC.	Invited speaker
2013	"Taking Advantage of Natural Experiments for Child Health: Understanding How Policy Impacts Child Health Quality, Costs, and Utilization". AcademyHealth Annual Research Meeting, Washington, DC.	Invited speaker
2013	"Understanding Contraceptive Use in the United States". American Public Health Association Annual Meeting; Boston, MA.	Invited moderator
2013	"Following the Passion: Embedding the DNA of Research in a Policy Translation Career". American Public Health Association Annual Meeting. Boston, MA	Invited panel presentation
2013	"The California Hot Spots Study: Insights into Neighborhood-level Factors Associated with Teenage Pregnancy". American Public Health Association Annual Meeting. Boston, MA.	Invited Panel presentation
2013	"Exploring and Understanding Newer Reproductive Health Technologies: LARC Provider Perspectives from Colorado and Iowa". American Public Health Association Annual Meeting. Boston, MA.	Invited panel presentation
2014	"Improving Adolescent Health: State Data Resources". AMCHP Annual Conference. Washington, DC.	Invited speaker
2014	"Current Issues in Adolescent and Young Adult Health". AMCHP Annual Conference. Washington, DC.	Invited speaker

2014	"Accelerating Progress for Adolescent Sexual Reproductive Health: Results from a Multi-Country Needs Assessment". World Bank Group, Washington, DC.	Invited speaker (with Decker, M)
2014	"Adolescent Development, Implications, and Policy Needs". Ohio Adolescent Health Partnership. Columbus, OH.	Keynote address
2014	"Realizing the Dream for Californians Eligible for Deferred Action for Childhood Arrivals (DACA): Health Coverage and Mental Health Stressors". Robert Wood Johnson Foundation Nursing and Health Policy Collaborative/University of New Mexico: Assessing the Impact of Immigration and Health Policy. November 21, 2014.	Invited speaker
2015	"Improving Contraceptive Options Now". Project Advisory Board Meeting, MDRC (organizing foundation). New York, NY.	Invited panelist
2015	"The Health and Well-being of Young Adults: Highlights from an Institute of Medicine/National Research Council Report". Society for Research in Child Development, Philadelphia, PA.	Roundtable discussion
2015	"The Impact of the Affordable Care Act on Women." California Wellness Foundation sponsored presentation by the Commonwealth Club of San Francisco. SF, CA. (audio http://bit.ly/1xJHr7c) http://www.commonwealthclub.org/events/2015-03-16/impact-affordable-care-act-women	Invited presentation
2015	"Adolescents & Young Adults in Title V Transformation: Understanding Needs, Designing & Selecting Measures, and Achieving Outcomes." AMCHP Annual Conference. Washington, DC, January 24, 2015.	Invited speaker
2015	"The Health & Well-Being of Young Adults." AMCHP Annual Conference. Washington, DC. Washington, DC. January 26, 2015.	Invited speaker
2015	"Young Adults on Campus: Confronting the Health Challenges." Society for Public Health Education Annual Meeting, Portland, OR. April 23, 2015	Plenary session
2015	'Partnering to Encourage Healthy Beverage Intake through Childcare: A Pilot Study." Pediatric Academic Societies (PAS), San Diego, CA. April 25-28, 2015.	Poster presentation

2015	"Strategies and Tactics for Achieving Meaningful Consumer Engagement in Health Care." AcademyHealth Advocacy Interest Group (ARM) Interest Group, June 13, 2015.	Invited panel presentation
2015	"In Their Own Words: Improving the Care Experience of Families with Children with Special Health Care Needs." AcademyHealth Child Health Services Interest Group, June 13, 2015.	Invited talk
2015	"Assuring Access and Use of Health Services by Adolescents and Young Adults under the ACA." U.S. Centers for Disease Control and Prevention, Atlanta, GA. August 17, 2015.	Invited presentation
2015	"Adolescents in the United States: Health Care for Adolescents: How to Improve it. U.S. Centers for Disease Control and Prevention, Grand Rounds. Atlanta, GA. August 18, 2015.	Invited panel Webinar
2016	"Assessing Youth-Friendly Health Services (YFHS) for Adolescent Sexual and Reproductive Health: A Systematic Review." Consortium of Universities for Global Health Conference. San Francisco, CA. April 9-11, 2016.	Poster presentation
2016	"Transforming HealthCare for Adolescents and Young Adults: Improving Quality and Access through Innovation and Collaboration." AMCHP Annual Conference, Washington, DC. April 6, 2016.	Lead panelist
2016	"Investing in the Health and Well-Being of Young Adults: A Health Profile of Young Adults: A Window of Opportunity for Early Cancer Intervention." Opportunities for Cancer Prevention During Early Adulthood, April 13, 2016, CDC National Association of Chronic Disease Directors. Decatur, GA.	Invited talk
2016	"Not Lost in Translational Science: Lessons Learned in Building a Research and Policy Pipeline." Emory University. Student Research Day, Atlanta, GA, April 21, 2016.	Keynote address
2016	"Make Your Own Adventure: Leadership in a Transformative Time" Emory University. Student Research Day, Atlanta, GA. April 21, 2016.	Invited talk
2016	"Policies: Health Equity Impact Assessment." WHO Collaborating Centre on Technology Assessment and Health Equity- Evidence, Process and Migrant Health, University of Ottawa, May 16, 2016.	Invited panelist

2016	"Evidence-Based Innovations to Support Women in Biomedical Research Careers." NIH Office of Research on Women's Health, Bethesda, MD. June 6, 2016.	Invited presentation
2016	"Policy Translation: A Multi-Method Approach to Evaluating California's Family Planning Policy and Program." Penn State College of Medicine: Division of Health Service and Behavioral Research: Seminar Series (Sponsored by BIRCWH Program). November 14, 2016.	Invited speaker
2016	"Mental Health Providers in School-Based Health Centers: A Potential Solution to Address Chronic Childhood Trauma." Forum on Promoting Children's Cognitive, Affective and Behavioral Health. The National Academies, Washington, DC. November 29, 2016.	Poster presentation
2017	"Advocacy for Global Family Planning/Reproductive Health Scale". IBP Consortium Meeting, Chaired by Public Health Institute, Oakland, CA. January 17, 2017.	Keynote address
2017	"Achieving relevance and visibility in an academic research career - opportunities and potential pitfalls." BIRCWH Leadership Webinar Series (Sponsored by BIRCWH Program). Webinar, June 15, 2017. https://youtu.be/4zaV92w1LuQ	Webinar
2017	"The Role of Long Acting Reversal Contraceptive: Taking the Pulse." American Public Health Association Annual Meeting, Atlanta, GA. November 6, 2017.	Invited presentation
2017	"Demonstrating School Health Center Impacts through a Results-Based Accountability Framework." American Public Health Association Annual Meeting, Atlanta, GA. November 6, 2017.	Poster presentation
2017	"Folks Do Fall Through the Cracks: Barriers to Care for Young Adults Churning Between Health Insurance Plans." American Public Health Association Annual Meeting, Atlanta, GA. November 6, 2017.	Invited presentation
2017	"Future Policy Directions for Opportunity Youth: Where Do We Go From Here?": Making Connections Matter for Adolescents. John Hopkins University, Baltimore, MA. December 6, 2017.	Invited presentation

2018	“Overview and Accomplishments of the AYAH-NRC National Strategies.” Society of Adolescent Health and Medicine, Seattle, WA. March 15, 2018.	Invited presentation
2018	“What’s New in Clinical Preventive Services? New Evidence, Guidelines, Policies – Challenges and Opportunities”. Society of Adolescent Health and Medicine, Seattle, WA. March 14-17, 2018.	Invited presentation
2018	“Healthcare at a Crossroads: Where Do We Go From Here?” Initiative for Regulation and Applied Economic Analysis Conference, Montana State University, Bozeman, MT. April 5-6, 2018.	Invited 2 presentations
2018	"Through The Looking Glass: The Role of Clinical Preventive Visits in Improving Adolescent Health". Oregon Pediatric Society Conference, Portland, OR, April 28, 2018.	Invited presentation
2018	"Creating Access to Care for Adolescent and Young Adult Males". 2018 National Adolescent and Young Adult Male Summit, Washington, DC. June 7, 2018.	Invited Keynote
2018	"Advancing Health Equity and Justice in California: A Landscape Analysis". Grantmakers in Health Conference. Chicago, IL, June 19, 2018.	Invited presentation
2019	“Use of Youth-Centered Mobile Health Application, Health-E You/Salud iTu, to Reduce Disparities in Contraceptive Knowledge, Access and Unintended Pregnancy Among Sexually Active Latina Adolescents”. Society for Adolescent Health and Medicine Annual Meeting, Washington, DC. March 6-8, 2019.	Poster presentation
2019	“The Promise of Adolescence”. Society of Preventions Research Annual Meeting. San Francisco, CA. May 30, 2019.	Roundtable discussion
2019	“Joining Forces: Advancing an Agenda for Adolescent Mental Health Services” AcademyHealth Summit on Teen Mental Health Crises. Washington, DC. June 5, 2019.	Invited presentation
2019	“Race, Gender, and Immigration Status: New Frontiers in Health Funding for Latinx”. GIH Annual Conference on Health Philanthropy. Seattle, WA. June 13, 2019.	Invited presentation

2019	"Walking the Walk: Applying Positive Youth Development Approaches to Adolescent Health". American Public Health Association, Office of Adolescent Health and Office of Population Affairs, Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services. June 18, 2019.	Invited webinar presentation
2019	“Migration roles in the Lives of Latina Youth: A Binational Comparison”. APHA Annual Meeting, Philadelphia, PA. November 4, 2019.	Invited presentation
2020	"The Promise of Adolescence" Health System Webinar. Board of Children, Youth, and Families. The National Academies of Science, Engineering, and Medicine. March 26, 2020.	Invited webinar presentation
2020	“Flourishing in Adolescence: Forum for Children’s Well-Being Spring Virtual Workshop". The Promise of Adolescence: Realizing Opportunity for All Youth. The National Academies of Science, Engineering, and Medicine. May 5, 2020.	Invited presentation
2023	Improving the Health and Well-Being of Adolescent and Young Adult Health through System Transformation, Committee on Improving the Health and Wellbeing of Children and Youth through Health Care System Transformation, National Academy of Science, Engineering, and Medicine, February 28, 2023	Invited Presenter
2023	National Academy of Sciences, Engineering, and Medicine, “After Roe: Physician Perspectives & Workforce Implications,” on May 25, 2023, you can view a recording of that event via the link below. https://nam.edu/event/after-dobbs-physician-perspectives-workforce-implications/	Session planner and moderator
2024	National Academy of Medicine, Council Meeting: Panel on the Standing Committee on Reproductive Health. Equity and Society	Session planner, speaker, and moderator
2024	National Academy of Sciences, Engineering and Health, Standing Committee on Reproductive Health, Equity and Society, Promising Strategies to Address Health Disparities Across the Reproductive Life Cycle. A Webinar	Session planner and moderator

2025	Implications For Primary Care of New Directions for Women's Health: Expanding Understanding, Improving Research, and Addressing Workforce Limitations, National Academy of Sciences, Engineering, and Medicine, Standing Committee on Primary Care|.	Speaker

INVITED PRESENTATIONS - REGIONAL AND OTHER INVITED PRESENTATIONS

2004	"Adolescent Pregnancy: A Current Profile and Dilemma for Clinicians and Other Decision makers," Clinical Conference of Child and Adolescent Psychiatry, Langley Porter, Psychiatric Institute, UCSF, San Francisco, CA	Invited lecture
2006	"The Use of Focus Group Research Methodology in Health Services Research," Health Policy Post-Doctoral Program, UCSF	Invited lecture
2006	"Conducting Effective Community Needs Assessments for Adolescent Health," Program in Maternal and Child Health, School of Public Health, UC Berkeley, CA	Invited lecture
2006	"A Profile of Adolescent Health – Miles to Go Before We Go to Sleep". Howard University Lecture Series, Washington DC	Invited lecture
2006	"Past, Present, and Future of Teenage Pregnancy Prevention", State of California, Maternal, Child, and Adolescent Branch, Teen Pregnancy Prevention Annual Meeting, Burlingame, CA	Keynote address
2006	"Adolescent Pregnancy and its Role in Health Disparities". Department of Health, DC-Baltimore Research Center on Child Health Disparities, Washington DC	Plenary talk
2006	"Creating a California Strategic Plan for Adolescents". California Adolescent Health Conference, Adolescent Health Collaborative, Oakland, CA	Plenary talk
2006	"Meeting the Needs of Adolescents in California". The California Wellness Foundation's Conference on Teenage Pregnancy Prevention, Oakland, CA	Keynote address
2006	"A Profile of Adolescent Health and Healthcare Coverage". Children's National Medical Center, Grand Rounds, Washington DC	Invited lecture
2006	"Teenage Pregnancy Prevention". Pediatric Grand Rounds, Department of Pediatrics, UCSF	Invited lecture
2007	"Future Directions in Teenage Pregnancy Prevention". The California Wellness Foundation Conference on Teenage Pregnancy Prevention, San Francisco, CA	Keynote address

2008	“Teenage Pregnancy Prevention --- Lessons Learned”. 5th Annual Conference: The Adolescent Working Group, San Francisco, CA	Plenary talk
2008	“The Family PACT Program: Evaluation Findings”. Family PACT Conference for California Counties: Optimizing Family PACT in a County Health System, Sacramento, CA	Invited talk
2008	"Parental Notification: What Can Be Learned from the Experience of Other States?" Grand Rounds, Department of Obstetrics, Gynecology, and Reproductive Health Sciences, UCSF, San Francisco, CA	Invited lecture
2008	"Translating Research in Policy: Lessons Learned". Institute for Health Policy Studies, Post-Doctoral Fellowship, UCSF, San Francisco, CA	Invited lecture
2008	“ Meeting the Needs of Immigrant Youth: Promising Directions”. The Center for Comparative Immigration Studies, (CCIS) Weaver Center, University of California, San Diego	Invited talk
2008	“Cross-Border Health: Creating an Agenda for Future Directions”. Global Health Forum, UCSF, San Francisco, CA	Invited talk
2009	“Adolescent Pregnancy Prevention: Making Progress and Not Losing Ground”. The California Wellness Foundation Conference on Teenage Pregnancy Prevention, Los Angeles, CA	Keynote address
2009	“A Profile of Adolescent Health – Beyond Teenage Pregnancy Prevention”. Adolescent Sexual Health Symposium, ACT for Youth Center of Excellence, New York, NY	Invited talk
2009	“Women’s Health in California – Making Inroads”. The California Wellness Foundation Conference on Women's Health, San Francisco, CA	Invited plenary talk
2009	Testimony on the Role of School Based Health Centers. State of California Assembly Legislature, Committee on Schools and Community, Informational Hearing	Invited talk
2009	“The Role of Teenage Pregnancy Prevention in Improving Economic Outcomes”. Berkeley Center on Health Economics and Family Security, University of California, Berkeley, CA	Invited panel moderator
2009	"Prevention of Adolescent Cancer". UCSF Helen Diller Comprehensive Cancer Center Annual Symposium: The Prevention of Cancer, San Francisco, CA	Invited speaker

2009	Expert Testimony on School Based Health Centers. State of California, Assembly Select Committee on Schools and Community	Invited speaker
2009	Health Care Reform (Part of a Mini-Medical School series), UCSF Medical School of Medicine, UCSF, San Francisco, CA	Invited lecture
2010	“Meeting the Needs of Pregnant and Parenting Adolescents – Evaluation Findings”. Adolescent Family Life Annual Conference, Oakland, CA	Invited speaker
2010	“Comparative Effectiveness Research: Opportunities and Challenges”. Clinical and Translational Science Institute and the San Francisco Coordinating Center, San Francisco, CA	Invited panelist
2010	“Qualitative Research Methods in Immigrant Health”. University of California Global Health Institute Center of Expertise on Migration and Health. First Annual Research Training Workshop. UC San Diego	Invited panelist
2010	“Health Care Reform in California: A UC View of Prospects and Challenges”. In cooperation with the California Senate Health Committee; California Program on Access to Care. UC Berkeley School of Public Health.	Invited presentation
2010	“Migration and Health in California”. University of California, Irvine Global Health Day.	Invited speaker
2010	“The Evaluation of the Family PACT Program”. School of Public Health, University of California, Berkeley.	Invited speaker
2010	"Teenage Pregnancy Prevention - What Lies Ahead?" The California Wellness Foundation Conference, San Francisco, CA	Invited speaker
2011	“Organizational Learning and Evaluation: Implications for Future Investments”. The California Wellness Foundation Conference, Los Angeles, CA	Invited speaker
2011	"Disparities in Health". Young Scholars Group, Department of Epidemiology and Biostatistics and CTSI, UCSF	Invited talk
2011	“Conducting Multi-Disciplinary Research in Family Planning Care". Bridging Interdisciplinary Research Careers in Women's Health (BIRCWH) health seminar series, UCSF	Invited talk
2011	“Promising Strategies: Improving Adolescent Health”. San Mateo County Teen Pregnancy Prevention Summit. San Mateo, CA.	Invited plenary speaker
2011	“Conducting Program Evaluation in Family Planning". Bixby Center for Global Reproductive Sciences Research Seminar. San Francisco, CA	Invited speaker

2012	“Reflections and Lessons Learned in Establishing the Women's Preventive Health Services”. 40th Annual Psychosocial Workshop. San Francisco, CA.	Invited keynote speaker
2012	“Lessons Learned in Developing a Research and Advocacy Career”. Clinic, Advocacy, Research and Training (CART) Group, Office of Developmental Primary Care, UCSF	Invited talk
2012	"Health Policy in Community Engagement". Fellowship of Fellows, UCSF	Invited talk
2012	Young Adult Health and Well-Being: Trends and Promises”. Promoting Positive Development in the Third Decade of Life: A Multidisciplinary and International Conference. Center for Advanced Study in the Behavioral Sciences, Stanford University, CA.	Invited panel presentation
2012	“Adolescent Health Insurance Coverage – How can the ACA Improve the Health of Adolescents”. Adolescent Health Care Conference. San Francisco, CA.	Invited Keynote
2012	“Migrant Health – Creating a Bi-National Agenda for Research". 7th Annual Summer Institute on Migration and Global Health.	Invited talk
2012	School of Medicine Pathways Explorers in Health and Society on Shaping a policy Translation Career.	Invited talk/panel
2012	“A Profile of Native American Adolescents in California”. State Indian Health Program. Sacramento, CA.	Invited talk
2013	“Health Care Reform”. Robert Wood Johnson Health and Society Policy Scholars Program. San Francisco, CA.	Invited lecture
2013	"Health Care Reform". (Part of a Mini-Medical School series), UCSF Medical School of Medicine, UCSF, San Francisco, CA	Invited lecture
2013	"Taking the Pulse and Moving Forward-Reducing Teenage Pregnancy in Santa Clara County". Santa Clara County Adolescent Pregnancy Prevention Network (APPN) Retreat.	Invited talk
2013	"Aligning Assets to Improve Community Health and Health Equity: SFHIP Lessons and Strategic Directions". San Francisco Health Improvement Partnerships. San Francisco, CA	Invited talk
2013	"Taking the Pulse: Improving the Health, Safety and Well-Being of Young Adults". UCSF Center for Vulnerable Populations Seminar Series, San Francisco, CA	Invited lecture
2013	“The Role of Program Evaluation and Advocacy”. Changing the World through Life Science Innovation Symposium. University of San Francisco, CA	Invited speaker

2013	"Adolescent and Young Adult Health: Implications for Public Health, Mental Health Policy, and Clinical Services". Department of Psychiatry, Child and Adolescent Psychiatry (CAP) Grand Rounds, UCSF, San Francisco, CA	Invited lecture
2013	"The Effect of Public Family Planning Services on Fertility". Implementation Science and the Global Response to HIV/AIDS. UCSF CFAR 2013 Symposium.	Invited speaker
2013	"Report Back from the Institute of Medicine Meeting: Improving the Health, Safety and Wellbeing of Young Adults". UCSF Center for Vulnerable Populations Seminar Series (also available as video at CHARM Website), San Francisco, CA	Invited lecture
2014	"Adolescent and Young Adult Health in San Francisco: Opportunities for Change". Health Working Group (AHWG), 11th Annual Provider Training: Patient-Centered Care for Young Women, San Francisco, CA	Keynote speaker
2014	"Funding Your Research Beyond the NIH". UCSF Faculty Development Day. UCSF Campus Council on Faculty Life. September, 2014	Invited panelist
2014	"How Will We Know it is Working: Monitoring the Impact of the ACA in Years to Come". PRL-IHPS-Osher Mini Medical School on Health Reform, UCSF, San Francisco, CA	Invited panelist
2014	“Assessing the Impact of Health Care Reform”. Health Policy Colloquium, UC Berkeley, Berkeley, CA	Invited panelist
2015	“Findings From the Family PACT Providers and Health Care Reform Implementation Study”. California State Department of Health Care Services. January 2015.	Invited presentation
2015	"No Federal Immigration Reform? What States Can Do to Improve the Health of Undocumented Workers". 2015 UC Global Health Day. UC Global Health Institute and UCLA. April 18 2015.	Plenary panel
2015	"Aligning Health Care and Social Determinants of Health". Spring Research Symposium: Healthy Communities Research at UC Berkeley. UC Berkeley School of Public Health. May 7, 2015	Invited talk
2016	"Alumni Health Care Roundtable on Health Care Reform". Moderator Janet Napolitano; Claire Brindis panelist. The (UCSF) Chancellor’s Breakfast/Alumni Weekend, San Francisco, April 9, 2016.	Invited panelist

2017	"Living in a Time of Uncertainty: Advancing Women's Health in 2017 and Beyond". UCSF Monthly Collaboratory Series. San Francisco, CA. January 12, 2017.	Moderator/panelist
2017	"Making an Impact in Science through Positive Influence". Leadership Panel: "Understanding, Bridging, Inspiring." UCSF Zuckerberg SFGH. Symposium, February 2, 2017.	Lead panelist
2017	"The Threat of the Trump Administration for Women's Access to Reproductive and other Preventive Health Services for Women". UCSF Community Dialogue for Women's Health, January 20, 2017.	Invited panelist
2017	"Lessons Learned in Translating Research into Policy." Research That Gets Results: A Symposium on Science-Driven Policy Change. Bixby Center for Global Reproductive Health. March 2, 2017.	Invited panel presentation
2017	"Science Advocacy 101". Forum with Vice Chancellor for Science Policy and Strategy. In the series of "Advocating for Science and Scientists in 2017 and Beyond." Graduate Division and the Science Policy Group at UCSF March 27, 2017. https://graduate.ucsf.edu/be-an-advocate	Invited panelist
2017	"Federal Policy in 2017: What Faculty Should Know and What They Can Do." University of California, San Francisco Academic Senate Division Meeting, May 11, 2017. https://senate.ucsf.edu/division-meeting.	Invited presentation
2017	"At the Policy Forefront: Evaluating California's Efforts in Assuring Access to Quality Reproductive Health." University of California, Sacramento Speakers Series: August 2, 2017. http://uccs.ucdavis.edu/events/2017-August-2-Brindis	Invited presentation
2017	"Trumpcare: Is It the Right Treatment for What Ails the American Health Care System?" Commonwealth Club, San Francisco. August 3, 2017.	Invited presentation
2017	"Lessons Learned in a Policy Translation Research Career". Dean's Forum on Public Service. Herbst Hall Auditorium, UCSF Mt Zion Campus. August 28, 2017.	Invited presentation
2017	"At Risk – Protecting Women's Health During a Time of Uncertainly." The Yale Alumni NonProfit Alliance, San Francisco. November 14, 2017.	Invited presentation
2017	UCSF Preterm Birth Initiative World Prematurity Day: The CA Policy Roundtable Working Toward a Policy Action Agenda. San Francisco, CA. November 15, 2017.	Invited session chair
2018	"Personal Leadership Development". Johnson & Johnson Foundation: GenH Challenge: Personal Leadership Development. San Francisco, CA. January 18, 2018.	Invited presentation

2018	"Mentorship and Sponsorship are Crucial to Career Development for Women Faculty". UCSF Faculty Mentoring Program. Mentorship and Sponsorship are Crucial to Career Development for Women Faculty. San Francisco, CA. January 31, 2018.	Invited panelist
2018	"Discussion on Childhood Mortality". Clinical and Translational Research Fellowship Journal Club, Discussion on Childhood Mortality. University of California, San Francisco, CA. February 15, 2018.	Expert discussant
2018	"The Role of Policy Research within Precision Medicine". Marcus Mixer2: Marcus Program in Precision Medicine Innovation (MPPMI), UCSF Research Development Office's Team Science Program. University of California, San Francisco, CA. February 21, 2018.	Invited speaker
2018	"The Role of Academic Centers within the Field". First Annual Colloquium on Population Health and Health Equity. University of California, San Francisco, CA. May 28, 2018.	Invited panelist
2018	"Theories, Design, Strategies, and Instruments for Evaluating Advocacy and Policy Change Initiatives". San Francisco Bay Area Evaluator's Workshop. San Francisco, CA, June 20, 2018	Invited presentation
2018	"Policy Translation: Lessons Learned". RISE Speaker Series, Center for Vulnerable Population. University of California, San Francisco, CA. July 11, 2018	Invited presentation
2018	"Lessons Learned in Developing a Policy Translational Career in Reproductive Health". Brown Bag Luncheon Series, Philip R. Lee Institute for Health Policy Studies. University of California, San Francisco, CA. August 21, 2018.	Invited presentation
2018	"Advancing Health Equity and Justice in California: A Landscape Analysis". Hispanics in Philanthropy Advancing Latino Health Equity Convening. Oakland, CA. November 7, 2018.	Invited presentation
2018	"Through the California Crystal Ball: A Health Landscape and Future Direction". National Advisory Council and Faculty Task Force, California Health Benefits Review Program Annual Meeting. Berkeley, CA. November 15, 2018.	Keynote speaker
2018	"Organizer of Within Your Reach: Using Implementation Science to Advance Your Team Science". UCSF Research Development Office's Team Science Program. University of California, San Francisco, CA. December 11, 2018.	Moderator

2019	"What comes next: How the midterm election results impact reproductive rights and health". California Preterm Birth Initiative Collaboratory Discussion Series. University of California, San Francisco, CA. December 13, 2018.	Moderator
2019	Writing for Policy Makers Workshop Series, 3 Part Series. Science Policy Group, University of California, San Francisco, CA. February 21 and March 4, 2019.	Moderator/panelist
2019	Translating Research into Policy Action, UCSF California Preterm Birth Initiative Grantee Workshop, University of California, CA. April 4, 2019.	Invited session chair
2019	Summer School: UC Network on Child Health, Poverty and Public Policy, UC Berkeley, CA. September 4, 2019.	Invited panelist
2019	"Surviving on Soft Money Environment". Building Interdisciplinary Research Careers in Women's Health (BIRCWH) Meeting, UC Davis, CA. October 7, 2019.	Moderator/panelist
2019	"Not Lost in Translational Science: Lessons Learned in Building a Research and Policy Pipeline". Global Health Science Seminar, UCSF, San Francisco, CA. October 31, 2019.	Invited presentation
2020	"The Promise and Challenges of the ACA for Women, Young Adults, and Adolescents ". Rossmoor Healthcare Forum. Myths, Realities and Options. Walnut Creek, CA. January 25, 2020.	Invited presentation
2021	"Recommendations on Diversity, Equity, and Inclusion in Health Services Research", AcademyHealth Annual Meeting, Washington, DC.	Invited Commentator
2023	Screening adolescents for Adverse Childhood Experiences (ACEs): Incorporating resilience and youth development	Invited Presentation
2024	Screening adolescents for Adverse Childhood Experiences (ACEs): Addressing the unique needs of immigrant youth ACES Aware Meeting, February 24,2023	Invited Presentation
2024	Lessons Learned in Career Advancement of Historically Exclused Faculty, UCSF Mid-Career Faculty Development Program	Invited Presentation
2025	NASEM Webinar : Promising Strategies to Address Health Disparities Across the Reproductive Health Lifecycle (https://www.nationalacademies.org/event/43065_07-2024_promising-strategies-to-address-health-disparities-across-the-reproductive-life-cycle-a-webinar) A Policy Framework for Advancing Environment and Health Outcomes, UC Center for Climate, Health and Equity	Panel Presentation

GOVERNMENT AND OTHER PROFESSIONAL SERVICE

1988 - 1991	Office of Technology Assessment Adolescent Health, U.S. Congress	Advisory Panel
1994 - 2000	Community Partnerships for Healthy Children Initiative, Sierra Health Foundation, Sacramento, California.	Evaluation
1995 - 2015	National Campaign to Prevent Teenage Pregnancy	Program Effectiveness Task Force, State and Local Leadership Task Force, Science into Policy National Advisory Latino Initiative
1995 - 2000	Community Coalition Partnership Programs for the Prevention of Adolescent Pregnancy, Centers for Disease Control and Prevention, Atlanta, Georgia	Consultant
1995 - 1997	Adolescent Pregnancy Prevention Initiative, The California Wellness Foundation.	Advisor
1995 - 2002	Adolescent Pregnancy Prevention Initiative, Johnson & Johnson Corporation and the National Organization for Adolescent Pregnancy and Parenting (NOAPP), Washington, DC	National Advisory Committee
1995 - 1995	Adolescent Health Work Group, Maternal and Child Health Bureau, U.S. Department of Health and Human Services.	Member
1996 - 1998	Steering Committee on Welfare Redesign, California Department of Social Services	Member
1996 - 2000	Adolescent Managed Care Advisory Committee Children Now, Oakland, California	Member
1996 - 2000	Georgia Campaign to Prevent Adolescent Pregnancy, Jane Fonda, Turner Foundation, Atlanta, Georgia	Consultant
1997 - 1997	Kaiser Kids Health Insurance Initiative, Kaiser Permanente Health Plan	Consultant
1997 - 1997	Year 2000 Community Initiative, David and Lucile Packard Foundation	Consultant
1998 - 1998	Community Partnerships to Reduce Teenage Pregnancies, The Flinn Foundation, Phoenix, Arizona	Consultant
1999 - 1999	Messengers and Methods for the New Millennium; A Round Table for Adolescents and Contraception. National Campaign to Prevent Teenage Pregnancy, and Advocates for Youth, Washington, DC	Member

1999 - present	National Teenage Pregnancy Prevention Research Center, University of Minnesota and Centers for Disease Control and Prevention	National Advisory Board
1999 - present	California Adolescent Health Collaborative	Co-Director and Executive Steering Committee Member
1996 - 1997	Advocates for Youth, Washington, DC	Program/Policy Committee Chair, Executive Committee, and Chair, Board of Directors
1996 - 1999	Frontiers of Research on Children, Youth, and Families Committee, Institute of Medicine National Research Council, Washington, DC	Member
1997 - 1997	Open Society Foundation, New York, NY	Advisor
1997 - 2000	Development of Community Guidelines for Preventive Services, Centers for Disease Control and Prevention, Atlanta, GA	Advisory Committee
1997 - 2000	Preventing Teen Pregnancy: Sharing Lessons Learned" Project. Centers for Disease Control and Prevention, and University of South Carolina, School of Public Health	Expert Panel
1997 - 2001	Board on Children, Youth, and Families, National Research Council, Institute of Medicine, Washington, DC	Forum on Adolescence
1997 - 2002	Adolescent Pregnancy Prevention Replication Project, Kansas Health Foundation	Technical Review Advisory Committee
1997 - 1997	Partnership for Information and Communication. Maternal and Child Health Bureau, Washington, DC	Inter-Organizational Workgroup
1997 - 1999	National Health Promotion and Disease Prevention Objectives for the Year 2010, Centers for Disease Control and Prevention	Core Work Group for Developing and Implementing Adolescent Health Objectives
1998 - 1998	Pan American Health Organization (PAHO), Division of Health Promotion and Protection, Family Health and Population Program, Washington, DC. Policies for Adolescents and Young Adults of the Americas	Advisory Group
1998 - 1998	Development of a Family Health Initiative, Maternal and Child Health Bureau, Washington, DC	Advisory Committee
1998 - 2000	Health Initiatives for Youth, San Francisco	Member, Adolescent Health Working Group
1998 - 2004	Centro Mujeres, La Paz, Baja California Sur, Mexico	Advisory Board

1998 - 2010	Addressing Barriers to Student Learning: Closing Gaps in School/Community Policy and Practice, Center for Mental Health in Schools, Department of Psychology, UCLA	Steering Group
1998 - 2001	Girl Neighborhood Power! Building Bright Futures for Success Initiative, Healthy Mothers, Healthy Babies Coalition, Washington, DC	Steering Committee
1999 - 1999	CDC Teen Pregnancy Prevention Consensus Panel on Replication, Atlanta, GA	Panel Member
1999 - 2002	Association of Maternal and Child Health Programs, Adolescent Data and Systems project (cooperative agreement with Centers for Disease Control and Prevention, Division of Adolescent and School Health)	Advisory Panel
1999 - 2002	Women's Health Report Card Project, National Women's Law Center, the Focus on the Health of Women Project of the University of Pennsylvania Medical Center, and the Lewin Group, Inc	National Advisory Board
2000 - 2001	Adolescent Report Card Project, Children Now, Oakland, California.	Member
2000 - 2002	Sexuality and Reproductive Health Expert Panel of the Health, Mental Health and Safety in Schools Guideline Project, American Academy of Pediatrics, funded by Maternal and Child Health Bureau, U.S. DHHS	Chair
2000 - 2002	Workgroup on Standardizing Adolescent Performance Measures, Association of Maternal and Child Health Programs, Washington, DC	Member
2001 - 2001	State Team, Joint Work Group on School-Based Teen Pregnancy Prevention, California Department of Education, California Department of Health Services, National School Boards Association, Washington, DC.	Team Member
2001 - 2001	Workgroup on Teen Pregnancy Prevention Programs, California Department of Health Services, Sacramento, California.	Member
2001 - 2001	Workgroup, Implementation of California's School Health Blueprint, California Department of Education and Department of Health, Sacramento, California.	Member

2001 - 2002	Women's Health Panel, Bright Futures for Women's Health and Well-Being: National Guidelines Project, Maternal & Child Health Bureau, DHHS, Washington, DC	Steering Committee; Chair, Adolescent Health Committee
2001 - 2004	Policy Committee, California Chlamydia Action Coalition, sponsored by the California Department of Health Services, California HealthCare Foundation, and the University of California, San Francisco.	Member
2001 - present	National Expert Panel, 2003 Children's National Health Survey, National Center for Health Statistics, funded by Bureau of Maternal and Child Health	Member
2002 - 2002	National Advisory Board, Georgia Campaign to Prevent Teenage Pregnancy, Jane Fonda, Executive Director	Member
2003 - 2005	Delivery Improvement, Technical Expert Panel Meeting, U.S. Public Health Title X, Washington, DC	Member
2003 - 2005	International Planned Parenthood Federation- Latin America Development of Peer Provider Manual Project	Consultant
2005 - 2005	Johns Hopkins School of Public Health Maternal and Child Health Training Program	Advisory Committee
2005 - 2005	Grantmakers for Children, Youth & Families Maternal and Child Health Issues	Advisory Committee
2005 - 2005	Public Policy Institute, California	Advisory Committee
2005 - 2007	Contributions from the Behavioral & Social Sciences in Reducing and Preventing Teen Motor Crashes Institute of Medicine and the Division of Behavioral and Social Sciences and Education. The National Academies of Sciences, Washington DC.	Committee Member
2006 - 2006	CDC Adolescent Sexual and Reproductive Health Portfolio (ASRH	Member, Expert Panel Review
2006 - 2006	Centers for Disease Control Health Promotion and Disease Prevention Research Centers: Reproductive Health and Review Panel, Atlanta, GA	Child & Adolescent Health Review Panel
2006 - 2010	NARAL, Pro-Choice America Foundation	Board of Directors, Chair, Program Committee
2007 - 2007	Federal Office of Population Affairs, Washington, DC	Technical Experts Advisory Committee

2007 - 2009	Institute of Medicine (IOM) Committee: A Comprehensive Review of the DHHS Office of Family Planning Title X Program	Member
2008 - 2008	CARTA Study on Adolescent Sexual Health Disparities	Consultant
2008 - 2008	Advisory Council, San Francisco County Adolescent Health Working Group, San Francisco, CA.	Member
2009 - 2020	National Adolescent Health Objectives 2020, Centers for Disease Control and Bureau of Maternal and Child Health	Consultant
2009 - 2022	National Institute of Health (NIH)	Ad Hoc Challenge Grant Reviewer,
2009 - 2010	California Breast Cancer Research Program Priority Setting Process, Oakland, CA	Policy Evaluation Advisor
2009 - 2011	Institute of Medicine (IOM) Committee on Pediatric Health and Health Care Quality Measures	Member
2009 - 2020	National Institute of Child Health and Human Development (NICHD)	Scientific Reviewer
2009 - 2010	Tipping Point Community, San Francisco, CA	Evaluation Consultant
2010 - 2015	Reproductive Life Plan, Education, Access to Health care in College High Risk (REACH) Teens California Leadership Advisory Group	Advisory Group Member
2010 - 2010	AcademyHealth Abstract Review Committee	Member
2010 - 2011	Institute of Medicine (IOM) Committee on Preventive Services for Women	Member
2010 - 2010	Centers for Disease Control and Prevention (CDC) Division of Adolescent School Health (DASH), Expert Panel	Consultant
2011 - 2012	Guttmacher Institute	Board of Directors
2011 - 2011	Office of Population Affairs (OPA), Office of Family Planning (OFP), and the Centers for Disease Control and Prevention. Revision of the Title X Family Planning Program Guidelines, Adolescent Panel	Member
2011 - 2018	Public Health Institute	Board Member
2011 - 2012	Guttmacher Institute	Board Member
2012 - 2012	Department of Health and Human Services (HHS) and Health Research Services Administration (HRSA) Office of Women's Health Expert Panel on Curriculum Development in Women's Health	Expert Panel Member

2012 - 2012	AcademyHealth Aetna-National Assembly on School-Based Health (NASBHC) Care Coordination	Advisory Committee Member
2012 - 2014	California Health Interview Survey (CHIS) Adolescent Technical Advisory Committee.	Chair
2013 - 2013	Department of Health and Human Services (HHS) and the Office of Adolescent Health (OAH) “Think Adolescent Health” agenda	Expert Panel Member
2013 - 2013	Department of Health and Human Services (HHS) and the Office of Adolescent Health (OAH) Technical Workgroup: Cost Study of Evidence-Based Teen Pregnancy Prevention (TPP) Programs.	Technical Working Group Member
2013 - 2013	National Academy of Medicine (NAM, formerly IOM) Workshop Panel	Member
2013 - 2014	Drexel University DrPH/Health Policy and Social Justice Advisory Committee	Committee Member
2013 - 2015	Patient Centered Outcomes Research Institute/PCORI Evaluation Group.	External Advisor
2013 - 2014	National Academies of Science (formerly IOM): Improving the Health, Safety and Well-being of Young Adults	Committee Member
2014 - present	National Academies of Science (formerly IOM) Interest Group: Health Policy and Health Care Systems	Committee Member
2015 - 2018	California Health Interview Survey (CHIS) Adolescent Technical Advisory Committee.	Chair
2015 - 2020	Centers for Disease Control and Prevention. Division of the National Health Interview Survey: The National Survey of Children’s Health	Technical Expert Panel Member
2016 - 2018	Public Health Institute (PHI) Audit Committee	Chair
2016 - 2018	California Health Interview Survey (CHIS) Teen Technical Advisory Committee (TAC)	Chair
2016 - 2020	Urban Institute: Beyond Birth Control Project: Family Planning and Women’s Lives Advisory Group	Consultant
2016 - 2018	National Academies of Sciences, Engineering, and Medicine’s (the Academies) Committee on Improving Health Outcomes in Children with Disabilities	Member
2017 - 2022	AcademyHealth	Board Secretary; Chair, Governance Committee, Membership Committee

2017 - 2018	John Hopkins Bloomberg School of Public Health: The Bloomberg American Health Initiative	National Advisory Board
2017 - 2018	California Health Interview Survey (CHIS) Adolescent Technical Advisory Committee.	Technical Advisory Committee
2018 - present	National Academy of Medicine, Committee on Science, Engineering and Medicine and Public Policy (COSEMPUP)	Committee Member
2018 - 2019	Urban Institute: Reproductive Health Care Access Group	Advisory Committee Member
2018 - 2019	National Academies of Sciences, Committee on Neurobiological and Socio-Behavioral Science of Adolescent Development and Its Applications	Committee Member
2018 - 2019	Campaign for Male Youth, The Partnership for Male Youth	Advisory Panel Committee
2018 - 2019	Adolescent Reproductive Health: Clinical Program Improvements Workgroup. Division of Reproductive Health, US Center for Disease Control and Prevention	Member
2019 - 2024	National Academy of Medicine, Diversity Committee	Member
2019 - present	Vanderbilt University Medical Center (VUMC)	Biomedical Science Advisory Board
2020 - 2021	CDC Developing and Evaluating Adolescent, Parent, and Provider Resources to Improve Adolescent Use of Sexual Health Services	Special Emphasis Panel Member

2021 – 2024	California Health Interview Survey (CHIS) Teen Technical Advisory Committee	Chair, Member
2022	Office of the Assistant Secretary for Preparedness and Response (ASPR), At-Risk Individuals (ARI) Program, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB), HHS Child and Adolescent Health Emergency Planning Toolkit:Guidance for Addressing the Needs of Children and Youth with Special Health Care Needs and their Peers	Subject Matter Expert
2022	Technical Expert Panel (TEP) to advise investigators conducting a systematic review on Respectful Maternity Care (RMC): Dissemination and Implementation of Perinatal Safety Culture to Improve Equitable Maternal Healthcare Delivery and Outcomes. University of Oregon.	Participant and Group Facilitator
2022	Planning committee for a research and data workshop: *Understanding the Full Impact of the Dobbs Decision,* AcademyHealth and The Commonwealth Fund.	Member
2022	NASEM: Identification and Prognosis of Low Birth Weight Babies and Disability Determinations	Report Review Monitor

UNIVERSITY AND PUBLIC SERVICE

SERVICE ACTIVITIES SUMMARY

In my interface between research and public policy, I am often called upon to help a variety of community groups, city, and county governments, as well as the federal government in helping to translate research findings for purposes of planning and development of new projects. For example, I have been called as an expert in program development for a number of states including California, Washington, Hawaii, South Carolina, New Mexico, Ohio, and Georgia in the areas of adolescent health policy, pregnancy prevention, and pregnancy treatment programs. With my methodological expertise in program evaluation, I have also provided brief consultation on how to best capture data and document both the short, as well as longer term outcomes, of their program efforts. A fulfilling experience was being invited by the State of California Governor's Office and Department of Health, beginning in the 1990s, to help develop a Teenage Pregnancy Prevention Initiative, based upon evidence and best practices. It was through these efforts that California implemented a wide portfolio of different community, media, and policy interventions that has contributed to our state's lead in decreasing the incidence of adolescent pregnancy throughout our country and across diverse ethnic and racial groups. Many of the programs that I recommended, based upon the existing evidence, continued to operate in communities throughout the state, funded by both federal and state funds, until the first decade of the 21st century. However, when the political climate turned, many of these programs were eliminated and I researched the impact of these closures on adolescents' access to reproductive

health information and services. This data was important for stakleholders concerned with programmatic closures and have been used to seek additional funding to re-start those programs. In another area, we also provided expertise to the state as they developed programs throughout the state aimed at helping women who are pregnant or parenting and who are chemically dependent.

On the national level, I served on the Patient Centered Outcomes Research Institute's (PCORI) Evaluation Group (PEG) Task Force, as part of PCORI's Research Integration and Evaluation team. The PEG is reviewing the impacts and effectiveness of PCORI. On a personal note, I was gratified to serve on several NAM (previously name the IOM) Report Committees; the most influential was the Committee on Preventive Health Services for Women, which developed recommendations for preventive services for women without co-payments as part of health care reform. All eight of our recommendations were accepted by the Obama Administration and were embedded in the Accountable Care Act. This resulted in over 150 million women receiving contraceptive coverage without co-payments since the recommendations were implemented.

I have also sought opportunities to more widely disseminate research information in formats that assist communities in being able to use research and program evaluation to help shape programs and policy. For example, in co-leading a research project pertaining to Latina childbearing, we were commissioned to develop a film aimed at state policy makers. Recognizing that the film would be useful for other groups, I sought to focus on its wide dissemination, not only in California, but nationally where the issue has become a pressing one for many communities that have not had the same history of programmatic efforts in this arena. I also sought to assure that the film would be available in Spanish, thus creating a resource for communities both in the US and in the Spanish speaking world. The film and a variety of educational materials are now available on our website for downloading, along with community guides providing suggestions for how to use the film in community settings.

In other arenas, I have been called upon to provide expert testimony both in Congress and in Sacramento as policy makers seek to identify viable models for improving the health of children and adolescents. I have also provided congressional staff briefings on topics that range from health care reform and the federal and state Children's Health Insurance Program, to violence prevention to adolescent pregnancy prevention. Long after the briefing is over, I continue to work with the policy staff to provide support as they attempt to incorporate evidence-based research into their policy decision-making. For example, I served on the Advisory Council for efforts sponsored by City and County of San Francisco Health Department focused on Increasing Patient-Centered Care for Young Women. I also served on the Steering Committee on a joint SF City and County Health Department and UCSF partnership (led at UCSF by Dr. Anda Kuo) to improve the coordination of health and well-being services for children and adolescents living in our county.

On our own campus, I balanced my responsibilities as the Philip R. Lee Institute for Health Policy Studies' (IHPS) previous Director, along with concurrent efforts to integrate the message of the importance of health services, population health, and health policy in a variety of campus initiatives, including Precision Medicine, the Bakar Computational Health Sciences Institute, (serving on the Executive Committee), the Health/Clinical Informatics Committee, and the Mid-Career Recruitment Committee. In addition, I represented IHPS on the Long-Range Development Planning Committee (LRDP), serving as a Liaison to its Community Advisory Group, as well as on the Bridge Funding Committee for 8 years. I also served on the School of Medicine (SOM) Campus Space Planning Committee and on the campus' Diversity Council, as well as the Limited Submission Review Committee. I have previously chaired or served on

several Chair/Dean recruitment committees, including Epidemiology and Biostatistics and the Dean of the School of Nursing, the School of Pharmacy, Department of Clinical Pharmacy and also, the Center for Pharmocoepidemiology, the Director of the Center for as well as Chairing or serving as a member of several university Stewardship Review Committees.

Even more “up- stream” has been my effort to serve (for the past 15 years) as a year-long mentor to individuals in under-represented groups as part of the Office of Outreach & Academic Advancement Post Baccalaureate program. In addition, I have been actively involved in mentoring and engaging a number of junior faculty on our campus, as well as being actively engaged in recruiting faculty “of color” to our campus. In these and other cases, I look beyond our campuses’ walls to consider how I can support these diverse faculty members as they transition to UCSF.

On a national level and post the 2022 Supreme Court decision to eliminate Roe v.Wade, I was asked by the Presidents of the National Academies of Science, Engineering, and Medicine (NASEM) to serve as Chair a Standing Committee entitled, Reproductive Health, Equity and Society (https://www.nationalacademies.org/our-work/standing-committee-on-reproductive-health-equity-and-society). This multi-disciplinary committee (2022-2024) evaluated the health, social, and economic implications of access to reproductive health care in the United States and globally in order to inform related program and activity development at NASEM. Our committee worked to implement a variety of papers, webinars, and Webpage that has served as a national resource to professionals, policy makers, and communities. Since 2023, I have also served as a member of the National Academy of Medicine Action Collaborative on Achieving a Climate Resilient and Sustainable Health Sector, a program of the NAM Climate Grand Challenge, focusing on improving metrics to document improvements and changes within health care systems.

UNIVERSITY SERVICE
UC SYSTEM AND MULTI-CAMPUS SERVICE

1996 - 2025	Maternal and Child Health Training Program, School of Public Health, UCB	Advisory Board
2007 - 2009	UC Santa Cruz-Silicon Valley Management School	Advisory Board
2000 - 2020	California Program on Access to Care, California Policy Research Center, University of California, Office of the President	Board Member
2005 - 2006	Inter-Campus Research Program on Children and Adolescent Health / UC Consortium on Children, Family and Community	Steering Committee
2006 - 2008	UC Mexus for the Social Sciences, Humanities & the Arts	Faculty Grants Review Committee
2007 - present	UCSF Global Health Sciences, UC Davis, UCB, UC San Diego, and UCLA	Steering Committee
2007 - present	UC Santa Cruz-Silicon Valley Management School	Advisory Board

2009 - present	UCB and UC Davis, Migration and Health Research Center (MAHRC)	Advisory Board Member
2009 - 2009	Health Services and Policy Analysis (HSPA), Division of Health Policy and Management, School of Public Health, University of California, Berkeley,	Affiliate Faculty Member
2010 - 2010	Review of Research Portfolio University of California, Office of the President	Expert Reviewer
2011 - 2017	Core Curriculum Committee for Multi-Campus University of California Global Health Initiative (UCGHI) MS in Global Health Program	Member
2012 - 2012	UC Berkeley's Center for Weight and Health California's Community Transformation Initiative (CACTI)	Advisory Board Member
2012 - 2014	California Health Interview Survey (CHIS) Adolescent Technical Advisory Committee	Chair
2014 - 2017	Maternal and Child Health, Measurement Research Network (MCH-MRN)	Co-Chair and Advisory Board Member
2015 - 2017	UC-Mexico Initiative Health Initiative of the Americas, Health Working Group (HWG)	Co-Chair and Member
2016 - 2020	The California Program on Access to Care (CPAC)	Chair and Member
2018 - 2022	UCLA Fielding School of Public Health, Research on ImmiGrant HealTh and State policy (RIGHTS)	Technical Advisory Committee Member
2018 - 2025	UC Berkeley's Center for Excellence (CoE) in Maternal and Child Health	Advisory Board Member
2020 – 2020	UC Riverside, Director of UC Mexico Programs	Search Advisory Committee
2024	UCLA Center for Health Policy – 30th Anniversary	Event Host Commitee

UCSF CAMPUSWIDE

1996 - 1999	Social and Behavioral Training in AIDS/HIV Research, Predoctoral training program, funded by University wide AIDS Research Program, sponsored by Department of Social and Behavioral Sciences, Center for AIDS Prevention Studies, and School of Nursing International Center for HIV/AIDS Research and Clinical Training Program	Advisor

1999 - 2001	Community-Based Research and Fellowship Program, Center for Health and Community	Advisory Board Member
2004 - 2004	Vice Chancellor's Community Partnership Task Force	Member
2004 - 2009	Chancellor's Council	Member
2004 - 2004	Stewardship Review, Institute for Health and Aging	Committee Member
2004 - 2006	Global Health Sciences, Research Subcommittee, Executive Committee, and Training Subcommittee	Member
2005 - 2006	Global Health Sciences Strategic Plan Working Group	Member
2006 - 2006	Program on Reproductive Health and the Environment (PRHE), Department of Obstetrics, Gynecology, and Reproductive Sciences	Advisory Committee
2006 - 2006	Center for Health and Community	Steering Committee
2006 - present	Program on Reproductive Health and the Environment (PRHE), Department of Obstetrics, Gynecology, and Reproductive Sciences	Advisory Committee,
2006 - 2009	Chancellor's Award for the Advancement of Women	Committee Chair
2007 - 2007	California Medicaid Research Institute (CaMRI), UCSF	Associate Director, Member, Steering Committee
2008 - 2008	Clinical and Translational Research Institute	Epidemiology Review Committee
2008 - 2009	Cardiovascular Research Institute	Member, Stewardship Review
2008 - 2010	UCSF Global Health Sciences Cuba Research Program in Health Diplomacy and Medical Education	Reviewer
2008 - 2011	Chancellor's Advisory Committee on the Status of Women (CACSW)	Member
2008 - present	UCSF SOM Post Baccalaureate Program	Faculty Advisor
2008 - 2012	Resource Allocation Program (RAP) Clinical and Translational Science Institute (CTSI)	Multidisciplinary Review Committee
2009 - 2009	Department of Epidemiology and Biostatistics	Faculty Search Committee
2009 - 2022	First Generation Program	Faculty Advisor
2010 - 2010	Stewardship Review, Institute on Health and Aging (Dr. Wendy Max)	Chair
2010 - 2010	Graduate Group, UCSF Global Health Sciences	Member

2010 - 2013	Health Policy and Social Sciences Review Committee, Resource Allocation Program (RAP); Clinical and Translational Science Institute (CTSI)	Member, Health Policy and Social Sciences Review Committee
2010 - 2012	UCSF Coordination Committee-the San Francisco Bay Health Improvement Program (SF Bay HIP)	Member
2010 - 2012	Chancellor's Long Range Development Plan Oversight Committee	Member
2011 - 2012	School of Medicine Leadership Retreat Planning Committee	Member
2011 - 2012	Search Committee for the position of Vice Dean, Academic Affairs and Faculty Development	Member
2011 - 2012	Chancellor's Martin Luther King Jr. Award Committee	Member
2011 - 2013	Limited Submissions Program (LSP)	Member, Steering Committee
2011 - 2014	Faculty Oversight Committee on Operational Excellence Initiatives	Member
2012 - present	Institute of Computational Health Sciences Executive Committee (ICHS)	Member
2013 - 2013	Search Committee for the position of Director of the Center for Health Professions	Member
2013 - 2013	International Research Advisory Council (IRAC)	Member
2013 - 2014	Search Committee for Executive Director, UCSF Center for Healthcare Value (CHV)	Member
2013 - present	Steering Committee, Precision Medicine	Member
2013 - 2018	Council on Campus Climate, Culture, and Inclusion (4CI)	Member
2014 - present	Search Committee, Dean, School of Medicine	Member
2014 - present	Graduate Group for the Doctoral Program, UCSF Institute for Global Health Science	Member
2014 - 2015	Knowledge Transfer Working Group, under the Benioff/Gates Pre-Term Birth Initiative	Co-Chair
2014 - 2020	UCSF Center for Vulnerable Populations	Member, Steering Committee
2015 - 2020	Multi-campus Research Programs and Initiatives: Sugar, Stress, Environments, and Weight Center (MRPI SSEW)	Member, Scientific Advisory Committee
2015 - 2020	Programming Committee for the Mission Bay East Campus Phase 1 Building	Member

2016 - 2016	Academic Senate's Committee on Academic Personnel (CAP) Stewardship Review Committee (SRC) (RE: Dr. Nancy E. Adler)	Review Committee Member
2017 - 2017	UCSF Faculty Mentoring Program Lifetime Achievement in Mentoring Award Selection Committee	Member
2017 - 2017	Search Committee for Chief of Cardiology, San Francisco VA Medical Center	Member
2019 – 2022	Mentorship and Sponsorship Task Force	Member
2024-2025	UCSF Latinx Center of Excellence and the California Health Care Foundation, Development of a Hispanic Health Chartbook	Advisory Board Member

SCHOOL OF MEDICINE

1996 - 2020	Institute for Health Policy Studies	Executive Advisory Committee
1998 - 1998	Faculty Review Committee, Institute for Health Policy Studies	Member
2000 - 2000	Ad Hoc Faculty Promotion Review Committee	Member
2000 - 2000	Ad Hoc Steering Committee for Integrated Clinical Studies	Member
2000 - 2000	Ad Hoc Search Committee	Member
2003 - 2005	Strategic Planning Committee, Institute for Health Policy Studies	Chair
2005 - 2007	Admissions Committee, School of Medicine	Member
2008 - 2008	Department of Obstetrics, Gynecology, and Reproductive Health Sciences	Faculty Search Committee
2008 - present	School of Medicine Post Baccalaureate Program	Faculty Advisor
2009 - 2009	Search Committee for the Division Chief, Department of Obstetrics, Gynecology and Reproductive Sciences at San Francisco General Hospital.	Member
2009 - 2009	Space Committee, School of Medicine	Member
2010 - 2010	Search Committee, Department of Epidemiology & Biostatistics	Member
2010 - 2010	Search Committee, Director of Health and Society Pathway	Member

2010 - 2010	Dean's Faculty Oversight Committee	Research Administration Liaison
2010 - 2010	Search Committee, Faculty joint position in Health and Breast Cancer Risk Assessment; Department of Surgery, and Philip R. Lee Institute for Health Policy Studies.	Member
2011 - 2011	Compensation Plan Project Steering Committee, School of Medicine	Member
2011 - 2011	School of Medicine Leadership Retreat Planning Committee	Member
2011 - 2019	Bridge Funding Committee, School of Medicine	Member
2013 - 2019	Internal Advisory Committee, Multidisciplinary Clinical Research Center (MCRC)	Member
2013 - present	Executive Committee, Institute for Computational Health Sciences (ICHS)	Member
2013 - 2020	Internal Advisory Committee, Multidisciplinary Clinical Research Center (MCRC)	Member
2015 - 2020	Building 33 Space Planning, Steering Committee	Member
2016 - 2017	Search Committee for New Chair, Department of Epidemiology and Biostatistics	Chair and Member
2018 - 2020	SOM Population Health and Health Equity Leadership Group	Member
2019 - 2020	SOM Dean's Strategic Plan Project: Clinical, Translational and Population Health Implementation Action Group (CTPH)	Member
2020 - 2020	Holly Smith Award Selection Committee	Member

2020 – 2021	Chairs and Directors Council on Diversity (CD2), Department Accountability Subcommittee	Member
2021 – present	Dr. Martin Luther King Jr. Faculty Leadership Award Selection Committee	Member
2021 – present	Center for Climate Change, Health, and Equity	Senior Advisor
2023-2024	Search Committee, Vice-Chancellor of Translational Research and Director, Clinical and Translational Science Institute (CTSI)	Chair
2024- present	Search Committee, UCSF National Clinician Scholars Program (NCSP)	Committee Member
2023-present	Strategic Advisory Group, Clinical and Translational Science Institute (CTSI)	Chair

SCHOOL OF PHARMACY

2023-2024	Search Committee for Chair, Department of Clinical Pharmacy	Chair
2025	Search Committee, Chair, Center for Pharmocoepidemiology	Chair

SCHOOL OF NURSING

2004 - 2004	Search Committee, Department of Family and Community Nursing	Ad Hoc Chair
2007 - 2007	Health Disparities Tenure Track Search Committee, School of Nursing	Member
2009 - 2010	Dean's Search Committee School of Nursing	Member

DEPARTMENTAL of PEDIATRICS

1996 - 1997	Second Year Medical School Training, Integrated Curriculum, Department of Pediatrics	Task Force
1996 - 2000	Division of Adolescent Medicine.	Executive Committee
1996 - 2001	Pediatric Clinical Research Center.	Advisory Committee
2000 - 2000	Fellowship Review, Department of Pediatrics	Committee Member
2001 - 2005	Health Services/Health Policy, Strategic Planning Group, Department of Pediatrics	Strategic Planning Group

2008 - 2010	Faculty Search Committee, Chair of Pediatrics, Department of Pediatrics	Committee Member
2015 - 2016	Chief Nutritionist Search Committee, Clinical and Research Program, Chair of Pediatrics, Department of Obstetrics, Gynecology, and Reproductive Health Sciences	Committee Member
2017 – 2018	Director Search Committee Chair, Bixby Center for Global Reproductive Health	Committee Member
2021 - 2023	Department of Pediatrics, Junior Research Faculty Review Committee for Clinical-Translational-Population Sciences Researchers	Co-Chair

COMMUNITY AND PUBLIC SERVICE

1995 - 1997	Adolescent Pregnancy Prevention Initiative, The California Wellness Foundation.	Advisor
1996 - 1998	Welfare Redesign, California Department of Social Services.	Steering Committee
1996 - 2000	Adolescent Managed Care, Children Now, Oakland, California.	Advisory Committee Member
1999 - 2020	California Adolescent Health Collaborative	Co-Director and Executive Steering Committee Member
2000 - 2001	Children Now, Oakland, California	Adolescent Report Card Project
2001 - 2001	State Team, Joint Work Group on School-Based Teen Pregnancy Prevention, California Department of Education, California Department of Health Services, National School Boards Association, Washington, DC.	Team Member
2001 - 2004	California Chlamydia Action Coalition, sponsored by the California Department of Health Services, California HealthCare Foundation, and the University of California, San Francisco.	Policy Committee
2001 - 2001	Teen Pregnancy Prevention Programs, California Department of Health Services, Sacramento, California	Workgroup Member
2001 - 2001	Implementation of California's School Health Blueprint, California Department of Education and Department of Health, Sacramento, California	Workgroup Member

2002 - 2002	Georgia Campaign to Prevent Teenage Pregnancy, Jane Fonda, Executive Director	National Advisory Board
2008 - 2008	San Francisco County Adolescent Health Working Group, San Francisco, CA.	Advisory Council
2009 - 2010	California Breast Cancer Research Program Priority Setting Process, Oakland, CA	Policy Evaluation Advisor
2009 - 2012	Tipping Point Community, San Francisco, CA	Evaluation Consultant
2013 - 2020	Healthy People 2020 Adolescent Workgroup, Washington DC	Workgroup Member
2014 - 2015	Too Small to Fail, Menlo Park, CA. Moderated by Hillary Clinton, 22 Adolescent Health experts invited to a roundtable discussion of the Clinton Foundation initiative on their efforts to improve the health and well-being of children ages zero to five. Ongoing involvement.	Panel Participant
2014 - 2018	Internal Reproductive Integrative Skin (IRIS), Increasing Patient-Centered Care for Young Women, City and County of San Francisco	Member, Advisory Council
2015 - 2019	Advisory Board, WestEd Justice & Prevention Research Center, Teen Pregnancy Prevention Program within the Oregon Youth Authority	Member

CONTRIBUTIONS TO DIVERSITY

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As a Spanish-speaking immigrant to the U.S. in the late 1950s, my professional research and public service activities focused on social disparities and equity have been shaped by the bullying and marginalization that I experienced initially as a non-English speaker. My public health training (Master's and Doctoral Degree) also provided me with an opportunity to understand from a theoretical perspective how structural factors, policies, and social inequalities shape the health of the public, specifically, access to health care services, education, and other economic platforms aimed at improving health and well-being.

Much of my research has focused upon the reproductive health needs of low-income women and men, as well as adolescents. For nearly 20 years, I led a team evaluating the Family PACT program, which cares for individuals up to 200% of poverty, with over two-thirds of the clients being of Latinx heritage. Our comprehensive evaluation led to quality improvement, as well as policies related to reimbursing clinics who served undocumented individuals, in spite of the Federal position not to reimburse for such services. Other health topics in which I have conducted diversity-relevant research, include: teenage pregnancy prevention program evaluation, pre-term birth initiatives, substance abuse treatment services, immigrant health, in particular, the impact of migration on the health of immigrants, the physical and mental health needs of Dreamers (Deferred Action for Childhood Arrivals), and the effectiveness of community-based clinics, school-based health centers, and community-based organizations focused on reducing asthma and increasing health care access. I have also conducted research studies

related to the needs of diverse adolescents and young adults' access to health insurance and health care access, with a strong emphasis on analyzing the data to further understand variations in patterns among ethnic and racially diverse young people. Most recently, my focus has turned to issues of social determinants of health and their impact upon health care access and utilization among marginalized populations.

I have also promoted diversity and equality opportunity through my service activities as a campus leader. I served as Chair of the Chancellor's Committee on the Advancement of Women from 2007 to 2009. During my tenure, I led efforts to conduct retreats for junior faculty pertaining to the "soft issues" inherent in career advancement. I have been delighted to see how many of the ideas during those events have been incorporated into the Faculty Development Day. As a result of some of these activities, I was gratified to be awarded the Chancellor's Award for the Advancement of Women in 2009. I have also served on the Irene Perstein Award Committee, aimed at supporting junior faculty, many who represent diverse backgrounds, at crucial moments in their career. Previously, I have also served on the Steering Committee of the UCSF Center for Vulnerable Populations.

I previously served as a member of the Council on Campus Climate, Culture, and Inclusion (4CI), chaired by Vice Chancellor of Diversity and Outreach, Dr. Renee Navarro (please see sections on research, teaching and service for additional examples of my commitment to diversity). Finally, I was asked to serve as the Co-Chair of a Committee on Pre-Natal Health as part of a major UC Office of the President-Mexico Binational Initiative, led by President Janet Napolitano and the Mexican Secretary of Health. The other two committee worked on topics related to Violence and Diabetes. I was honored to share my responsibilities with the Director of Mexico's NIH Perinatal Health. A number of bi-national research exchanges were established as a result of this endeavor, as well as a funded research projects that compares the birthing experiences of Mexican adolescents in Mexico and California.

Most recently, I led a team that collaborated with Hispanics in Philanthropy completing a new report entitled, *Taking A Pulse: Latinx Health Equity in California—Facing Disparities and Building for the Future for Hispanics in Philanthropy*. A special symposium highlighting the results was held as a means of engaging potential federal and state private and public funders to support new projects aimed at ameliorating racial/ethnic disparities in health among the Latinx population. This is in alignment with my engagement as one of the national advisors on Dr. Alicia Fernandez's federally-funded UCSF Latinx Center of Excellence. At UCSF and nationally, I play a role in shaping the types of experiences of future diverse leaders and scholars receive, including serving as PI of the NIH-Building Interdisciplinary Careers in Women's Health (BIRCWH) and the UCSF/Genentech Mid-Career Development Program Advisory Committee, as well as serving as the evaluator of the ARCHES Program (Advancing the Career of Historically Excluded Scholars). I serve on UCSF's National Clinician Scholars Program Leadership Council and Chair of the Strategic Advisory Group for the UCSF-CTSI Initiative, serving as the evaluator of CTSI's impact evaluation.

TEACHING AND MENTORING

TEACHING SUMMARY

My primary teaching activities at UCSF focus on formal teaching within Pediatrics 180.01D, the core seminar for adolescent medicine. The program is the longest continually funded national training program in Adolescent Medicine (since 1977) and is one of seven federally funded interdisciplinary training programs in Adolescent Medicine. I also guest lecture in other courses offered in the Schools of Medicine, Pharmacy, and Nursing at UCSF and the UC Berkeley,

School of Public Health, as well as advising post-doctoral, doctoral, and master's degree students within the School of Medicine and School of Nursing. Most recently, I have become an affiliated member of the Institute for Global Health Sciences, where I have chaired the Doctoral Committee for 6 of their Doctoral students, as well as serving on three Thesis Defense Committees. In addition, for 17 years, I was the Director and primary faculty member of the William and Flora Hewlett Foundation Postdoctoral fellowship in Reproductive Health policy and Program Evaluation for Latin American scholars. Under my guidance, the program successfully graduated more than 30 fellows from Mexico, Peru, Venezuela, Columbia, Nicaragua, El Salvador, Guatemala, and Brazil, many of whom are involved in senior academic and government positions with high levels of influence in their respective countries. I also conduct seminars in research methodology, program evaluation, reproductive health, and adolescent health in several training programs. As an example of other types of professional teaching, I have conducted several health policy lectures that have been taped for the UCTV website, and downloaded throughout the state, nationally, and internationally, along with webinars shown nationally through the federal Maternal and Child Health Bureau.

I have also worked across 10 UC campuses in the development of a UC system-wide Global Health Institute. We successfully competed and were awarded planning and implementation grants for two of the 3 initially selected areas: Immigrant and Transborder Health and Women's Health and Empowerment. Previously, I also served as an evaluation consultant on the UCSF-MUHAS Tanzania Twinning project funded by the Gates Foundation. This program focused on the curriculum reform of the 5 school MUHAS campus: Medicine, Pharmacy, Nursing, Dentistry and Public Health. I have also developed a number of teaching aids that are being used both at UCSF and in a number of campuses across the country, for example, a long-distance learning course on adolescent health, a Resource Curriculum on Adolescent Health for Schools of Public Health, in collaboration with the Association of Schools of Public Health, as well as power point presentations on Latino Adolescent Reproductive Health, Young Adult Health, and the impact of the Affordable Care Act (ACA). Most recently, I led and/or served as the moderator of 4 national webinars on the subject of adolescent health and disparities, and the ACA and adolescents and young adults, all of which have been widely disseminated. In addition, I either taught or moderated three sessions in a 6 part Mini-Medical School series on health policy, which is available through UCTV (http://www.uctv.tv). Along with other health policy lectures sponsored by the Institute (mentioned above), these have been downloaded by over 3 million viewers.

During my tenure as Director of the Philip R. Lee Institute for Health Policy Studies (IHPS), the emergence of a dynamic relationship between UCSF and UC Hastings (now known as UC School of Law) provided the opportunity to establish an innovative master's program that focuses squarely on health policy and law. In 2009, the UCSF-UC Hastings Consortium on Law, Science, and Health Policy was initiated to develop and support interdisciplinary collaboration on subjects at the intersections of these fields through education, research, and clinical training and service. The Consortium established programs in all three areas and has also spearheaded the development of a formal affiliation agreement between the universities, which supported the launching of the MS in Health Policy and the Law (HPL). This exciting endeavor, led by Drs. Daniel Dohan (Professor, DAHSM and IHPS Associate Director for Training and Development) and David Faigman (UC Hastings College of Law, now Dean) was launched in Fall 2016. It is a one-year or two year-part time program designed to prepare students to be effective researchers and leaders in a dynamic new landscape, whether in health policy research or in health law. The MS HPL targets individuals with backgrounds in the clinical sciences, health sciences, public heath, public policy, or law.

To kick-start planning and implementation of this effort, we developed a proposal and were awarded the campus' second Chancellor's Education Innovation Award by the Executive Vice Chancellor and Provost's (EVCP) Office, representing a $400,000 loan to support the development of the new MS HPL. Our collaborative partner, Dr. Catherine Lucey, Vice Dean for Education in the SOM, has been instrumental in the degree's development. We were also fortunate to have the support of campus leadership (including Graduate Division Dean Elizabeth Watkins, former Librarian Karen Butter, former Vice Chancellor Joe Castro, School of Nursing Professor Mary Louise Fleming), and other expert faculty at UCSF and UC Hastings. The MS HPL represents a major commitment and is part of a larger coordinated effort by the Chancellor/EVCP and SOM, to establish a campus–wide, on-line program (vendor-supported) and WASC-approved degree. The MS HPL is being conferred by UCSF and UC Hastings, jointly taught, and originally administered by PRL-IHPS (now, under the auspices of UC School of Law). During my tenure as IHPS Director, we graduated two cohorts of students. I previously participated in the development of course material on program evaluation and was invited to become affiliated faculty member of UC Hastings School of Law. In addition, I serve as the Co-Investigator of the NIH-funded Building Interdisciplinary Research Careers in Women's Health (BIRCWH), which supports 3 fellows per year to conduct basic, translational, and policy research in women's health. The program the country's longest serving program in the U.S. and celebrated its 20th anniversary in 2020.

Most recently, I was gratified to lead efforts for a new AHRQ T-32 in collaboration with UC Berkeley, which supports doctoral degree program students in public health, and two post-doctoral fellows at IHPS. Finally, IHPS serves as one of the National Clinical Scholars sites (8 in total), bringing together the School of Medicine and School of Nursing. IHPS is the home for this new endeavor that builds upon the previously successful RWJ Clinical Scholars program and I serve on its Leadership Council.

FORMAL TEACHING AT UCSF (2004-2020)

	Academic Yr	Course No. & Title	Teaching Contribution	School	Class Size
	2004 - 2004	Adolescent Pregnancy: A Current Profile and Dilemma for Clinicians and Other Decision makers," Clinical Conference of Child and Adolescent Psychiatry, Langley Porter, Psychiatric Institute	Guest Lecturer		150
	2006 - 2006	"The Use of Focus Group Research Methodology in Health Services Research," Health Policy Post-Doctoral Program, UCSF	Lecturer		30
	2006 - 2006	"Conducting Effective Community Needs Assessments for Adolescent Health," Program in Maternal and Child Health, School of Public Health, UCB	Guest Lecturer		25

Prepared: July 2, 2025

	Academic Yr	Course No. & Title	Teaching Contribution	School	Class Size
	2006 - 2006	"Evaluation Methods Applied to School-Based Health Clinics," School of Nursing	Guest Lecturer		20
	2007 - 2007	Latino Adolescent Pregnancy Prevention. 2nd Year Medical School Elective	Guest Lecturer		30
	2008 - 2008	Parental Notification: What can be learned from the experience of other states? Grand Rounds, Department of Obstetrics, Gynecology, and Reproductive Health Sciences	Guest Lecturer		70
	2008 - 2008	Translating Research in Policy: Lessons Learned. Institute for Health Policy Studies, Post-Doctoral Fellowship.	Guest Lecturer		20
	2008 - 2008	Pediatrics Core Seminar 180.01D	Lectures and responsible for Health Policy Core		15 - 20
	2008 - 2009	Adolescent Sexual Health in the Latina population, Latina Issues Elective, UCSF School of Medicine.	Guest Lecturer		40 - 60
	2009 - 2009	Health Care Reform (Part of a Mini-Medical School series)	Guest Lecturer		60
	2010 - 2017	Pediatrics Core Seminar 180.01D	Guest Lecturer		25
	2013 - 2013	Taking the Pulse: Improving the Health, Safety and Well-Being of Young Adults. UCSF Center for Vulnerable Populations Seminar Series	Guest Lecturer		20
	2013 - 2013	Adolescent and Young Adult Health: Implications for Public Health, Mental Health Policy, and Clinical Services. UCSF Department of Psychiatry; Psychiatry, Child and Adolescent Psychiatry (CAP) Grand Rounds	Guest Lecturer		20
	2013 - 2013	Building Interdisciplinary Research Careers in Women's Health (BIRCWH)	Guest Lecturer		20

	Academic Yr	Course No. & Title	Teaching Contribution	School	Class Size
	2013 - 2013	Health Care Reform (Part of a Mini-Medical School series)	Guest Lecturer/Panelist		80
	2013 - 2013	Report Back from Institute of Medicine Meeting: Improving the Health, Safety and Wellbeing of Young Adults. UCSF Center for Vulnerable Populations Seminar Series (also available as video at CHARM Website) Sept. 9, 2013	Guest Lecturer		50
	2014 - 2014	How Will We Know it is Working: Monitoring the Impact of the ACA in Years to Come. UCSF IHPS-Osher Mini Medical School on Health Reform	Panel Member		80

MENTORING SUMMARY

As a Latina faculty member, I am particularly sought by Latinx students who are interested in my serving as a content and career mentor. I am the primary mentor for four to six fellows (Pediatrics, Adolescent and Young Adult Health, and Obstetrics/Gynecology and Reproductive Health Sciences, Institute for Global Health) each year, and I often meet with other postdoctoral fellows, graduate students, junior and senior faculty to discuss research designs, program development, grant development, and career development. I have been gratified to receive uniformly glowing comments from these interactions. I have also had an outstanding record in mentoring my large staff of researchers and helping them along in their career development, as well as the junior and senior faculty of IHPS.

As one of a relatively small number of Latina women in leadership on our campus, I have defined the area of mentoring of diverse trainees to be an important priority and responsibility, not only for the Institute, but also for the campus in general. As an immigrant, I have a particular sensitivity to the promotion of diversity and enhancing the opportunities of our faculty, trainees, and staff. I am a proud participant in our campus' First-Generation Initiative (First to go to college-FG2C), formally and informally mentoring a number of medical, nursing, pharmacy, and dentistry students.

I also recognize that at this point in my career, I am promoting other faculty and research staff to provide lectures that I have been invited to provide for decades. This is part of the teaching-mentoring and transition focus as IHPS Director and as Distinguished Professor of Pediatrics and Health Policy (Recall).

In recognition of my role as mentor across UC campuses, I was invited to also join the faculty at the UCLA School of Public Health, Center for Health Policy. I was gratified to receive the UCSF Campus Mentoring Lifetime Achievement in Mentoring Award in 2016, as well as honored in 2018 as one of the UC Berkeley School of Public Health's Most Influential Alumni (as part of their celebration of the School's 75th Anniversary) (among other honors).

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PREDOCTORAL STUDENTS SUPERVISED OR MENTORED

Dates	Name	Program or School	Role	Current Position
1990 - 1991	Marilyn Price	MSW, UCB	Research Advisor	
1990 - 1991	Margaret Martin	MPH, UCB	Research Advisor	
1990 - 1991	Chris Betzold	Master's in Nursing, UCSF	Research Advisor	
1990 - 1991	Sean Casey	MPH, UCB	Research Advisor	Research Associate, Alameda County Health Department
1990 - 1991	Myrna Epstein	MPH, UCB	Research Advisor	
1990 - 1991	Cate Teuten	MPH, UCB	Research Advisor	
1990 - 1991	Amy Wolfe	MPH, UCB and Nurse Practitioner, UCSF School of Nursing	Research Advisor	Nurse Practitioner, San Francisco County Health Department
1990 - 1991	Lee Smith	PhD, School of Nursing, UCSF	Research Advisor	
1990 - 1991	Christina Mellin	MPH, UCB	Research Advisor	
1990 - 1991	Pec Inman	PhD, School of Educational Psychology, U San Francisco	Research Advisor, Career Mentor	Assistant Professor, San Jose State University
1990 - 1991	Patricia Blasé	PhD, School of Nursing, UCSF	Research Advisor	
1990 - 1992	Georgiana Coray	PhD, School of Nursing, UCSF	Research Advisor	Nurse Director, San Diego (Deceased, 2010)
1990 - 1991	Wendy Jameson	MPH, UCB	Research Advisor	
1991 - 1992	Faith Wolfson	MSW, UCB	Research Advisor	
1991 - 1992	Lynn Wittenberg	MPH, UCB	Research Advisor	Research Associate
1991 - 1992	Meg Royce	MPH, UCB	Research Advisor	

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Dates	Name	Program or School	Role	Current Position
1991 - 1992	Gina Sucato	MD, School of Medicine, U Pennsylvania	Research Advisor	Assistant Professor, Department of Pediatrics, U of Pittsburgh School of Medicine
1991 - 1992	Ila Rosen	MPH, San Francisco State University	Research Advisor	
1991 - 1993	Jesus Ramirez	MPH, UCB	Research Advisor	
1991 - 1993	Tam Nguyen	MA/Public Policy, UCB	Research Advisor	
1991 - 1993	Jaime Geaga	PA, MPH, UCB	Research Advisor	
1992 - 1993	Faith Wolfson	MSW, UCB	Research Advisor	
1992 - 1993	Zandy Kidd	MPH, UCB	Research Advisor	
1992 - 1993	Victoria Fontana	MSW, UCB	Research Advisor	
1992 - 1993	Rebecca Brook	BA/Health Law, UCLA	Research Advisor	
1992 - 1993	Michelle Pearl	MPH, UCB	Research Advisor	
1993 - 1996	Sheri Tye	MPH, UCB	Research Advisor	
1993 - 1994	Renu Karir	Joint Master's, Yale School of Management, Yale School of Public Health	Research Advisor	
1993 - 1994	Julia Cohen	MA/Public Policy, UCB	Research Advisor	
1992 - 1992	Susan Kools	PhD, School of Nursing, UCSF	Research Advisor, Career Mentor	Professor,School of Nursing, UCSF
1993 - 1994	Susan Starbuck-Morales	DrPH, School of Public Health, UCB	Research Advisor	Researcher, Humboldt State University
1993 - 1996	Susan Proctor	PhD, School of Nursing, UCSF	Research Advisor	
1993 - 1994	Diane Melendez	PhD, Division of Medical Anthropology, UCSF	Research Advisor	
1995 - 1995	Meg Wise	MPH, MSW, UCB	Research Advisor	

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Dates	Name	Program or School	Role	Current Position
1995 - 1996	Sarah Teagle	PhD, School of Public Health, UCB	Research Advisor	Senior Researcher, RTI
1995 - 1998	Claire Horton	MD, School of Medicine, Emory and MPH, U North Carolina, Chapel Hill	Research Advisor	Clinical Faculty, San Francisco General Hospital
1995 - 1996	Margaret Martin	DrPH, School of Public Health, UCLA	Research Advisor	
1995 - 1996	Ellen Stein	MD,MPH, UCB	Research Advisor	
1995 - 1996	Neva Phair	Joint Program in Medical Sciences, UCB	Research Advisor	
1995 - 1998	Nicole Wicox	MPH, UCB	Research Advisor	Physician, San Francisco
1996 - 1998	Parag Nene	MD, School of Medicine, U Pennsylvania	Research Advisor	
1997 - 1998	Rupal Sangvhi	MPH	Research Advisor	Independent Consultant
1997 - 2000	Xochitl Castaneda	PhD, Department of Anthropology, Amsterdam University	Research Advisor	Director, UCB Mexican-US Border Initiative (now retired)
1998 - 1999	Carolyn Bradner	MD, School of Medicine, U Chicago and Post Doctoral Fellow, UCSF	Research Advisor, Career Mentor	Professor, Department of Pediatrics and Adolescent Medicine, UCSF
1998 - 2000	Deborah Sattley	MSW, School of Social Work, U Illinois	Research Advisor	Consultant
1998 - 2000	Sherri Tye	PhD, School of Public Health, UCB	Research Advisor	Parent
1999 - 2000	Monya Day	BA, Stanford	Research Advisor	
1999 - 2000	Kate Heumann	Master's in Public Policy, UCB	Research Advisor	

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Dates	Name	Program or School	Role	Current Position
2000 - 2001	Sara Buckelew	MD, MPH, UCB and Post-Doctoral Fellow, UCSF	Research Advisor	Professor, Adolescent Medicine, Department of Pediatrics, UCSF
2001 - 2001	Olivia Simpson	MD, MPH, UCB	Research Advisor	
2001 - 2001	May Moo Podus	MPH, San Jose State University	Research Advisor	
2002 - 2002	Hilary Spindler	MD, Yale and PhD, UCLA	Research Advisor	UCSF, Global Health Research Associate
2002 - 2004	Signy Judd	PhD, School of Nursing, UCSF	Research Advisor	Research Coordinator, UCSF
2002 - 2003	Shrimant Mishra	MD, MPH,UCB	Research Advisor	
2002 - 2003	Gorette Amaral	MPH, UCB	Research Advisor	Ph.D., Stanford
2002 - 2003	Mona Jhuar	MPH, UCLA	Research Advisor	Program Officer, The California Endowment
2002 - 2004	Katrine Lofberg	MD, Medical School, U Washington, Seattle	Research Advisor, Career Mentor	Physician, Washington State U
2002 - 2004	Andrew Mihalek	MD, Medical School, UCD	Research Advisor, Career Mentor	Professor of Pulmonary Medicine, University of Virginia
2002 - 2004	Kristine Penner	Joint UCB/UCSF MD Program, MPH, UCB	Research Advisor	
2002 - 2007	Alexa Curtis	PhD, School of Nursing, UCSF	Research Advisor	Nurse Practitioner, Humboldt County, CA
2003 - 2005	Lisa Romero	DrPH, School of Public Health, UCB	Research Adivsor	Project Officer, CDC

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Dates	Name	Program or School	Role	Current Position
2003 - 2005	Sonia Jain	PhD, Harvard U	Research Advisor	Research Director, West-Ed, San Francisco
2003 - 2005	Beth Chaton	PhD, LaVerne College, Claremont, CA	Research Advisor, Career Mentor	Program Director, Department of Education, Humboldt County, CA
2004 - 2005	Sarah Shulman	MS, PhD Oxford	Research Advisor	Director, Youth Development Organization
2005 - 2007	Lauren Ralph	MPH, UCB	Research Advisor	Assistant Professor, Department of Ob/Gyn, UCSF
2006 - 2007	Wanwadee Neamsakul	PhD, School of Nursing, UCSF	Research Advisor	Faculty Member, U Indonesia
2006 - 2007	Marcia Wertz	PhD, School of Nursing, UCSF	Research Advisor, Career Mentor	Assistant Professor, School of Nursing, UCSF
2007 - 2010	Linet Oyucho	PhD, Great Lakes U Kisumu, Kenya	Research Advisor	Lecturer, Doctoral Student, U of Ottawa
2007 - 2008	Alexis Armekanis	MD, Medical School, UCSF	Research Advisor	Psychiatry Resident, UCSF
2007 - 2009	Dawn Richardson	DrPH, School of Public Health, UCB	Research Advisor	Post Doctoral Fellow, Health & Society, U Michigan
2007 - 2009	Naomi Schapiro	PhD, School of Nursing, UCSF	Research Advisor	Clinical Professor, Family Health Care Nursing, UCSF
2007 - 2009	Nan Jiang	PhD School of Public Health, Indiana U, Bloomington	Research Advisor	Post-doctorate in Tobacco Policy, UCSF
2009 - 2009	Elodia Villasenor	MPH, San Francisco State University	Research Advisor	

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Dates	Name	Program or School	Role	Current Position
2009 - 2010	Olubosola Olewole Busola	BA, Post-Bac Program, UCSF	Research Advisor	Post Bachelor Program/UCSF
2010 - 2012	Manuelito Biag	MPH, PhD, UC Davis	Career Mentor	Social Science Research Associate, Stanford University
2012 - 2012	Heather Knauer	MPH, UCB	Career Mentor	Research Associate, PRL-IHPS, UCSF
2012 - 2012	Nora Anderson	MPA, New York University	Career Mentor	Research Associate, PRL-IHPS, UCSF
2012 - 2012	Nicole Bennett	MPH	Career Mentor	Research Associate, PRL-IHPS, UCSF
2013 - 2014	Rachel Siemons	BA Postbac- Pre-med program, Bryn Mawr College	Thesis mentor	UC Berkeley-UCSF Joint Medical Program
2011 - 2013	Paulette Cha	BA Postbac- Pre-med program, Bryn Mawr College	Thesis Mentor	UCSF-UC Berkeley (now: Public Policy Institute, San Francisco
2013 - 2013	Heidi Moseson	2nd year doctoral student at UCSF	Career Mentor	Doctoral program in Epidemiology at UCSF
2013 - 2013	Luis A. Rodríguez	RD, CNSC	Career Mentor	UCSF Medical Center/Children's Hospital
2013 - 2013	Satu Larson	2nd year doctoral student at UCSF	Career Mentor and Qualifying Exam member	Doctoral program in at S/N UCSF
2014 - 2014	Carlos Penilla	DrPH Student	Research and Career Mentoring	Assistant Professor, Department of Pediatrics, UCSF
2014 - 2015	Zesmayat Mekonnen	MA, first year mentor program	first year mentor program	UCSF

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Dates	Name	Program or School	Role	Current Position
2015 - 2016	Leena Bhalerao Singh	MA	Qualifying Exam committee	UCB
2015 - 2016	Sara Kassabian	MA	Mentee/Trainee	Independent Consultant
2016 - 2017	Sophie Godley	MPH, Clinical Assistant Professor	Mentee	Boston University School of Public Health
2016 - 2017	Grace Liu	MPH	Mentee	UCSF Global Health Sciences
2016 - 2017	Joseph Chuang	MS, MPHc	Mentee	University of Washington
2016 - 2017	Stacy Osua	BA	Mentee	UCSF, Post Baccalaureate Program
2016 - 2017	Ana Isabel Gonzalez	MA, MPH	Mentee	UCB, accepted for PhD program, University of Texas
2016 - 2017	Carmen Maria Conroy	BA	Mentee	Yale NIH PREP research fellow
2017 - 2018	Lauren Lee Caton	BA, MS (2018)	Mentee	UCB, Public Health, Maternal and Child Health
2017 - 2018	Cynthia Shen	BA in progress	Mentee	Cornell 2020
2018 - 2019	Alex Valenzuela	BS Human Biology	Mentee	UCSF
2018 - 2019	Fiona Ng	RN, Master of Science in Nursing Student	Mentee	UCSF, Pediatric Nurse Practitioner candidate 2019
2019-2020	Aricelle Sanchez	UCSF Post-Bachelor's Program	Mentee	UC Irvine, School of Medicine
2019 – 2021	Jamie Sawyer	PhD Student	Mentee	
2020-2021	Leonida Radford	UCSF Post-Bachelor's Program	Mentee	University of Washington, School of Medicine

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Dates	Name	Program or School	Role	Current Position
2020 – present	Jane Fieldhouse	PhD Student, Global Health	Mentee	
2021-2022	Urania Argueta	UCSF Post-Bachelor's Program	Mentee	UCSF, School of Medicine
2021-2022	Monica Gutierrez	Applying to Medical School	Mentee	
2021-2025	Sarah Nathan	PhD Student, Social & Behavioral Sciences	Mentee	
2022-2023	Marie Salem	Research Assoc/Pre PhD Student	Mentee	PhD Program
2022-2023	Julia Hankin	Research Assoc/Pre PhD Student	Mentee	Apply to PhD program
2023-2024	Kyle Lakatos	Medical Student	Mentee	Internship, UCLA
2022-present	Sammer Elsayed	PhD Student, Global Health	Mentee	Ph.D.Global Health
2023- present	Julia Holmes Ryan	Ph.D. UC Berkeley School of Public Health	Mentee	Ph.D. Student
2025-present	Sigal Maya	Ph.D. Global Health	Mentee	Ph.D. Student
2024-present	Jacquelyn Roger	Ph.D. Biomedical Informatics, UCSF	Mentee and Research Supervisor	Ph.D. Student

POSTDOCTORAL FELLOWS AND RESIDENTS MENTORED

Dates	Name	Fellow	Faculty Role	Current Position
1983 - 1985	Barbara Staggers, MD, MPH	Fellowship in Adolescent Medicine	Research, Professional Mentoring	Chief, Teen Clinics, Children's Hospital, Oakland

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Dates	Name	Fellow	Faculty Role	Current Position
1984 - 1986	Martin Anderson, MD, MPH	Fellowship in Adolescent Medicine	Professional Development	Chief, Division. of Adolescent Medicine, UCLA
1985 - 1988	Sheryl Ryan, MD, MPH	Fellowship in Adolescent Medicine	Professional Development	Chief, Division of. Adolescent Medicine, Yale University
1989 - 1991	Trude Bennett, DrPH	Hewlett Fellow	Research and Career advisor	Professor, School of Public Health, University of North Carolina
1990 - 1991	Jesus Jaime Guzman, MD	Hewlett Fellow, Mexico	Research advisor	Professor, Universidad de Guadalajara, Mexico
1990 - 1991	Noe Alfaro, MD, MPH	Hewlett Fellow, Mexico	Research Advisor	Professor, Universidad de Guadalajara, Mexico
1990 - 1991	Laura Laski, MD, MPH	Hewlett Fellow, Argentina	Research Advisor	Director, UN Family Planning Program, New York
1991 - 1992	Juan Carlos Ramirez Rodriguez, MD	Hewlett Fellow, Mexico	Research Advisor	Professor, Universidad de Guadalajara, Mexico

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Dates	Name	Fellow	Faculty Role	Current Position
1991 - 1995	Jonathan Ellen, MD	Fellowship in Adolescent Medicine	Research and Professional Development	Professor/Vice Chair of Pediatrics, Johns Hopkins
1991 - 1995	Cynthia Kapphahn, MD, MPH	Fellowship in Adolescent Medicine.	Research and Professional Development	Associate Professor, Pediatrics Stanford
1992 - 1993	Elena Fuentes-Afflick, MD, MPH	Hewlett Fellow, US	Research Advisor	Professor, Department of Pediatrics, UCSF
1992 - 1993	Julio Garcia, MD	Hewlett Fellow, Mexico	Research Advisor	
1993 - 1994	Monica Jasis, MD	Hewlett Fellow, Mexico	Research Advisor	Director, Centro Mujeres, Baja, Mexico
1993 - 1995	Isabelle Melese-d'Hospital, PhD	Hewlett Fellow, Mexico	Research Advisor	
1993 - 1996	David Bell, MD	Fellowship in Adolescent Medicine.	Research and Professional Development	Assistant Professor, Pediatrics, Columbia University
1994 - 1995	Gabriela Rodriguez, MS	Hewlett Fellow, Mexico	Research Advisor	Research Director, Family Planning Program, Mexico City, Mexico

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Dates	Name	Fellow	Faculty Role	Current Position
1995 - 1996	Mariana Romero, MD	Hewlett Fellow, Argentina	Research Advisor	Medical Director, Family Planning Program, (CEDES) Buenos Aires, Argentina
1996 - 1997	Rosario Cardenas, MD	Hewlett Fellow, Mexico	Research Advisor	
1996 - 1997	Elena Zuniga, BA, PhD candidate	Hewlett Fellow, Mexico	Research Advisor	Director, UN Family Planning Program, El Salvador
1997 - 2000	Howard Pinderhughes, MD	Scholar, WT Grant	Research Advisor, Career mentor	Professor and Chair, School of Nursing, Social & Behavioral Sciences, School of Nursing, UCSF.
1998 - 2002	Mary Ott, MD	U. of Pennsylvania and Postdoctoral Fellow in Adolescent Medicine	Research Advisor, Career Mentor	Associate Professor, Indiana University, Dept. of Pediatrics
1998 - 2000	Arik Marcell, MD	Fellowship in Adolescent Medicine	Research Advisor, Career Mentor	Associate Professor, Johns Hopkins University, Adolescent Medicine

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Dates	Name	Fellow	Faculty Role	Current Position
1998 - 2000	Martha Perry	Fellowship in Adolescent Medicine	Research Advisor	
1996 - 1997	Xochitl Castenada, BA, PhD	Hewlett Fellow, El Salvador and Mexico	Research Advisor	Director, Health Initiatives of the Americas, Berkeley, CA (now retired)
1997 - 1998	Jesus Chirinos, MD	Hewlett Fellow, Peru	Research Advisor	Professor, Catholic University, Lima, Peru
1997 - 1998	Maria Vivas-Mendoza, MD	Hewlett Fellow, Mexico	Research Advisor	
1998 - 1999	Guillermo Canton Calderon, MD	Hewlett Fellow, Guatemala	Research Advisor	Physician, Guatemala City, Guatemala
1998 - 1999	Maria Soledad Gonzales Montes, PhD	Hewlett Fellow, Mexico	Research Advisor	
1999 - 2000	Freddy Javier Cardenas, MD	Hewlett Fellow, Nicaragua	Research Advisor	Professor, University of Nicaragua
1999 - 2000	Enriqueta Valdez, MD	Hewlett Fellow, Mexico	Research Advisor	
2000 - 2001	Susana Chavez, MA	Hewlett Fellow, Peru	Research Advisor	
2000 - 2001	Simon Nadew, MD	Visiting Fellow	Research Advisor	Medical resident, Family Practice, Ethiopia

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Dates	Name	Fellow	Faculty Role	Current Position
2000 - 2001	Diana Martinez, MD	Hewlett Fellow, El Salvador and Mexico	Research Advisor	
2000 - 2003	Sophia Yen, MD	Fellowship in Adolescent Medicine	Research and Professional Development.	Clinical Instructor, Adolescent Medicine, Stanford University
2001 - 2002	Maria Claudia Gutierrez, MA	Hewlett Fellow, Columbia	Research Advisor	
2001 - 2002	Jane Pirkis, PhD	Harkness International Health Policy Scholar, Australia	Research Mentor	Senior Lecturer, Melbourne University Australia
2001 - 2002	Addis Abeba Salinas, MD, MA	Hewlett Fellow, Mexico	Research and Career Advisor	
2002 - 2003	David Breland, MD	Fellowship in Adolescent medicine	Research Advisor	Assistant Professor, Pediatrics, University of Washington
2002 - 2003	V. Melvin Sotelo, MA	Hewlett Fellow, Nicaragua	Research and Career Advisor	Family Planning Coordinator, Nicaragua
2002 - 2003	Lillian Wong, MD	Visiting Scholar	Program Director: Research, Clinical, Professional Dev.	Faculty, Chinese University of Hong Kong
2002 - 2003	Raquel Hurtado, MD	Hewlett Fellow, Peru	Research and Career Advisor	

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Dates	Name	Fellow	Faculty Role	Current Position
2003 - 2003	Loris Hwang, PhD	Fellowship in Adolescent Medicine	Career Advisor	Associate Adjunct Professor, Pediatrics/ Adolescent Medicine, UCSF
2003 - 2004	Erica Troncoso, MA	Hewlett Fellow, Mexico	Research Advisor	
2003 - 2004	Carmen Elisa Alvarez, MS	Hewlett Fellow, Columbia	Research Advisor	
2004 - 2005	Roberto Casto-Perez, MD	Hewlett Fellow, Mexico	Research and Career Advisor	Professor, School of Public Health, Mexico
2004 - 2005	Cecilia de Mello e Souza, MD	Hewlett Fellow, Brazil	Research Advisor	Professor, Sao Paolo, Brazil
2004 - 2006	Jane Burns, PhD	Harkness International Health Policy Scholar, Australia	Program Director, Research Mentor	Evaluation Director, Imagine, Australia
2006 - 2006	Jennifer Yu, PhD	Postdoctoral Fellow, Agency for Health Care Quality and Research, IHPS	Research Advisor, Career Mentor	Research Associate, IHPS, UCSF
2006 - 2008	Aimee Afable-Munsuz, PhD	Postdoctoral Fellow, Agency for Health Care Quality and Research, IHPS	Research Advisor, Career Mentor	Postdoctoral Fellowship, School of Pharmacy, UCSF

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Dates	Name	Fellow	Faculty Role	Current Position
2007 - 2008	Kim Rhoades, MD, MS, MPH	Postdoctoral Fellow, Agency for Health Care Quality and Research, IHPS Philip R. Lee Fellow, UCSF	Research, Career Mentor	Professor of Surgery and Community Research, UCSF
2008 - 2009	Helena Hart, MD	Philip R. Lee Fellow, IHPS, UCSF	Research, Career Mentor	Medical School, UCSF
2009 - 2012	Christine Dehlendorf, MD, MAS	Department of Family and Community Medicine, UCSF	Research, Career Mentor	Clinical Professor of Medicine, Department of Family and Community Medicine, UCSF
2008 - 2012	Amy Donovan-Blondell, PhD	Department of Health and Aging, UCSF	Research, Career Mentor	Post Doc Fellowship, Institute for Health and Aging, UCSF Now: Independent Consultant
2009 - 2011	Pam Stoddard, PhD	Philip R. Lee IHPS Post-Doc	Career Mentor	Post Doc, Philip R. Lee Institute for Health Policy Studies, UCSF
2009 - 2012	Anisha Patel, MD	Philip R. Lee Fellow, IHPS, UCSF	Research, Career Mentor	Stanford University

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Dates	Name	Fellow	Faculty Role	Current Position
2011 - 2014	Sarah, Isquick, MD, MPH	Doris Duke Fellow, Philip R. Lee IHPS, Bixby Center	Career Mentor	Practicing Physician, Sutter Health
2011 - 2013	Elizabeth Uy-Smith, MD, MPH	Primary Care Research Fellow	Career Mentor	Family and Community Medicine
2013 - 2017	Marissa Raymond-Flesch, MD, MPH	Fellow	Career Mentor	Current: Associate Professor, Adolescent and Young Adult Medicine
2013 - 2017	Satu Larson	Fellow	Career Mentor	Associate professor for SJSU School of Nursing, a pediatric nurse practitioner
2013 - 2014	Esme Cullen	Third Year Medical Student	Career Mentor	UCSF Medical Center
2013 - 2018	Paulette Cha	PhD Candidate	Career Mentor	Public Policy Institute, San Francisco
2014 - 2016	Gina Robinson	PhD, UCSF	Career Mentor	School of Nursing, UCSF
2014 - 2017	Michelle Ko	MD, PRL-IHPS Fellow	Career Mentor	Professor, UC Davis School of Medicine
2014 - 2017	Suzane M. Martinez, MD, PhD	MD, PhD	Career Mentor	UCOP

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Dates	Name	Fellow	Faculty Role	Current Position
2014 - present	Sarah Combellick, MA	Research Associate	Career Mentor	PhD candidate, UC Davis
2014 - 2016	Jacquelyn Torres, PhD, MD	Fellow	Career Mentor	Assistant Professor, Department of Epi/Biostatistics, UCSF
2015 - present	Elizabeth Dickson, RN, MSN	Fellow, RWJF Nursing and Health Policy Collaborative	Career Mentor, Dissertation Committee	Faculty (tenure-track) University of New Mexico, College of Nursing
2015 - 2017	Ilana Garcia-Grossman	MD Candidate, class of 2018	Career Mentor	UCSF
2016 - 2018	Emily Behar, RN, MSN, MPH	Doctoral Student, Global Health Sciences	PhD, Career Mentor	Department of Public Health, San Francisco
2016 - 2018	Jennifer Shen	Fellow	Research and career mentoring	IHPS Postdoctoral Fellow
2016 - 2018	Emily Hall, RN, MSN, MPH	Doctoral Student	PhD, Career Mentor	San Francisco Department of Public Health
2018 - 2020	Lauren Strelitz, MD, MSL	PhD Candidate, Fellowship in Adolescent Medicine	Career Mentor and Scholarly Oversight Committee	Dept. of Pediatrics, UCSF

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Dates	Name	Fellow	Faculty Role	Current Position
2018 - 2020	Marichianah Onono, MBChB, Msc	Doctoral Student, Global Health Sciences	Qualifying Exam Committee & Chair	Kenya Medical Research Institute
2018 - present	Jayme Congdon	Fellow	Career Mentor	Depart. of Pediatrics, UCSF
2019 - present	Angela Barney, MD	Clinical Fellow	Career Mentor and Scholarly Oversight Committee	Depart of Pediatrics, UCSF
2024- present	Clemence Marty	Visiting Fellow	Career Mentor	Head of Strategy and Transformation, Assistance Publique–Hôpitaux de Paris (AP–HP)
2024-present	Jennifer Yarger	Post-doctoral Fellow	Mentor	Department of Urology
2024-present	Juliana Friend	Post-doctoral Fellow	Mentor	Department of Epidemiology and IHPS
2024-present	Kristen Burke	Post-doctoral Fellow, BIRCWH	Mentor	Post-Doctoral Program

FACULTY MENTORING

Dates	Name	Position while Mentored	cbrindisMentoring Role	Current Position
1999 - 2001	Marty Jessup	PhD, School of Nursing, UCSF	Research Advisor	Associate Professor, School of Nursing, UCSF.
2005 - 2006	Kristine Madsen	MD, MPH	Research Advisor	Assistant Adjunct Professor, Pediatrics, UCSF
2005 - 2007	Jennifer Reich, PhD	Postdoctoral Fellow, IHPS	Research and Career mentoring	Professor, U of Denver
2005 - present	Daniel Dohan, PhD	Associate Professor Department of Anthropology and Health Policy	Career Advisor	Deputy Director and Professor, Director of Training/IHPS/ UCSF
2005 - present	Diana Greene Foster, PhD	Demographer	Research and Career Advisor	Assistant Professor, Department of Obstetrics, Gynecology, and Reproductive Health Sciences, UCSF
2006 - 2011	Mary Ott, PhD	Faculty, Indiana U Bloomington	Research supervision and career mentoring	Faculty, Indiana University, Bloomington
2006 - 2020	Tracy Weitz, PhD	Department of Sociology, UCSF	Research and career mentor	Professor, American University

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Dates	Name	Position while Mentored	cbrindisMentoring Role	Current Position
2006 - 2020	Tracey Woodruff, PhD	Post-Doc and Faculty member, UCSF	Research and career mentor	Professor, Dept. of Obstetrics, Gynecology and Reproductive Sciences, UCSF
2007 - 2020	Jeff Belkora, PhD	Assistant Professor in Research, Surgery and Health Policy	Research and career mentoring	Associate Professor in residence, Department of Surgery and IHPS, UCSF
2007 - 2019	Michael Cabana, MD, MPH	Associate Professor, Chief of General Pediatrics, UCSF	Research review and personal advisor	Chair of Pediatrics, Montefiore, New York, NY
2007 - 2016	Diane Rittenhouse, MD	Associate Professor in Residence	Career mentor	Professor in Residence, Department of Family & Community Medicine and IHPS, UCSF
2008 - 2012	David Becker, MD	Assistant Clinical Professor of Pediatrics	Research and career mentoring	Clinical Professor of Pediatrics, UCSF
2008 - 2014	Sara Buckelew, MD, MPH	Assistant Clinical Professor	Career mentoring	Clinical Professor, Department of Pediatrics, UCSF

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Dates	Name	Position while Mentored	cbrindisMentoring Role	Current Position
2008 - 2012	Adam Hersh, MD	Clinical Fellow and Assistant Professor, Dept. of Pediatrics, UCSF	Research and career mentoring	Professor, Department of Pediatrics, University of Utah
2008 - 2011	Megie Okumura, MD	Assistant Adjunct Professor, Dept. of Pediatrics, UCSF	Research and career mentoring	Associate Professor, Department of Pediatrics, UCSF
2008 - 2014	Laura Schmidt, PhD, MPH, MSW	Associate Professor in Residence	Career mentor	Professor, IHPS, and the Department of Anthropology and History, UCSF and History, UCSF
2008 - 2014	Steve Takemoto, PhD	Assistant Adjunct Professor	Career mentor	Independent Consultant
2010 - 2016	Tilly Gurman, DrPH	Assistant Professor	Career mentor	Assistant Professor, Department of Global Health, School of Public Health and Health Services, George Washington University
2010 - 2016	Ushma Upadhyay, MPH	Assistant Professor	Research and career mentoring	Associate Professor, Bixby Center for Global and Reproductive Health

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Dates	Name	Position while Mentored	cbrindisMentoring Role	Current Position
2013 - present	Anisha Patel, MD	Assistant Professor	Research and career mentoring	Professor, Department of Pediatrics, UCSF
2013 - present	May Sudhinaraset, PhD	Assistant Professor	Research and career mentoring	Professor, School of Public Health, UCLA
2018 - 2019	Fatima Rodriquez, MD, MPH, FACC	Assistant Professor	research and career mentoring	Assistant Professor Cardiovascular Medicine, Stanford University School of Medicine
2019-present	Cristin Kearns, DDS	Assistant Professor	Career mentor	Assistant Professor, School of Dentistry, UCSF
2019-present	Rita Hamad, MD	Assistant Professor	Career mentor	Professor, School of Public Health, Harvard
2018-2021	Brittany Chambers, PhD	Assistant Professor	Career and research mentor	Assistant Professor, UC Davis School of Medicine
2019-present	Romina Barral, MD	Assistant Professor	Career and research mentor	Assistant Professor, Univ of Missouri-Kansas, School of Medicine

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Dates	Name	Position while Mentored	cbrindisMentoring Role	Current Position
2020-present	Ifeyinwa Asiodu, RN, PhD	Assistant Professor	Career and research Mentor	Associate Professor, Department of Family Health cSchool of Nursing, UCSF
2020-persent	Jayme Congdon. MD	Assistant Professor	Career and research Mentor	Assistant Professor, Department of Pediatrics, UCSF
2022-present	Anita Hargrave, MD	Assistant Professor	Career and research mentor	Assistant Professor, Department of Medicine, UCSF
2022-2024	Susanna Mitro, Ph.D.	BIRCWCH Scholar	Career and research Mentor	Kaiser Division of Research
2022-present	Julia Raney, M.D.	Assistant Professor, Department of Pediatrics, UCSF	Mentor and Research Collaborator	Assistant Professor
2022-oresent	Kenshata Watkins, MD	Assistant Professor, Department of Emergency Medicine	Mentor	Assistant Professor, Department of Emergency Medicine
2023-present	Akinyemi Oni-Orinsan. Ph.D.	Associate Professor, School of Pharmacy	Mentor	Associate Professor, School of Pharmacy
2024-present	Amanda Bryson, MD	Assistant Professor, Department of Pediatrics, UCSF	Mentor and Research Collaborator	Assistant Professor

Prepared: July 2, 2025

Dates	Name	Position while Mentored	cbrindisMentoring Role	Current Position
2023-present	Ayesha Appa, PhD	Assistant Professor, Department of Medicine, UCSF	Mentor	Assistant Professor
2020-present	Jason Nagata, MD	Associate Professor, Department of Pediatrics, UCSF	Mentor and Research Collaborato	Associate Professor
2022-present	Ribka Tessera, MD	Researcher, Kaiser Division of Research, Oakland	Mentor	Researcher
2023-present	April Bell, Ph.D.	Assistant Professor, Department of Famly and Community Medicine	Mentor	Assistant Professor
2024-present	Jonathan Watanabe, Ph.D.	Professor and Director, Department of Clinical Pharmacolog y	Mentor	Professor and Director, Department of Clinical Pharmacology
2024-present	Lucy Ogbu-Nwobodo, MD	Assistant Profesor, Department of Psychiatry	Mentor	Assistant Profesor, Department of Psychiatry
2025-present	April Edwill, MD	Assistant Professor, Department of Pediatrics	Mentor	Assistant Professor, Department of Pediatrics
2024-present	Enihomo Obadan-Udoh, DDS.	Associate Professor, School of Dentistry	Mentor	Associate Professor, School of Dentistry

Prepared: July 2, 2025

Dates	Name	Position while Mentored	cbrindisMentoring Role	Current Position
2024-present	Meghan Morris	Associate Professor and Vice Chair in the Department of Epidemiology and Biostatistics	Mentor	Associate Professor and Vice Chair in the Department of Epidemiology and Biostatistics
2025-present	Yasaswi Kirlovskiy, MD	Assistant Professor, Department of Obstetrics, Gynecology and Reproductive Health Sciences	Mentor	Assistant Professor

RESEARCH AND CREATIVE ACTIVITIES

RESEARCH AND CREATIVE ACTIVITIES SUMMARY

Methodologically, I conduct program evaluations and health policy analyses, using a variety of quantitative and qualitative techniques, assuring triangulation of data. This strength enables me to work with a variety of research collaborators, including previously valuating: 1) the nation's largest 1115 Medicaid Waiver Family Planning Waiver; 2) California's statewide, community-based teenage pregnancy prevention, as well as pregnant and parenting adolescents initiatives; 3) school-based health services; 4) the impact of the Affordable Care Act (ACA) on children, adolescents, young adults and women's health; 5) the role of patient engagement in health care system redesign, 6) UCSF-CA preterm birth initiative, 7) health care access and needs of immigrants, with a particular focus on Deferred Action for Childhood Arrivals (DACAs), 8) the interaction of Adverse Childhood Experiences (ACEs) and the needs of adolescents, and 9) monitoring the impact of COVID-19 . As a result of my work in the area of program evaluation, I collaborated with Dr. Annette Gardner in the writing of a book, *Advocacy and Policy Change Evaluation: Theory and Practice*, published by Stanford Press in 2017.

In 2018-2019, along with a small number of campus leaders (Nancy Adler, Kirsten Bibbins-Domingo, Kevin Grumbach, Bob Hiatt, and Elizabeth Watkins), we established the UCSF Population Health Sciences and Health Equity Initiative that brings together multiple ongoing efforts in this area, but which are often not recognized as a special campus strength. We held a successful UCSF Colloquium on Population Health & Health Equity (https://www.youtube.com/watch?v=MXqy_LIIExI) in May 2018 and I gave a presentation on the role of academic health centers in population health. We conducted a campus-wide study of the

data needs of our faculty in the area of population health and large data bases, working towards creating a data repository and the systematic identification of campus experts who are able to work with faculty and trainees in conducting population-health oriented analyses.

With the selection of Dr. Bibbins-Domingo as the inaugural Vice-Dean for Population Health and Health Equity, I served on her Steering Committee until 2020, planning a variety of strategies to build upon our campus' strengths in this arena and leverage further collaborations across campus related to population health. I served as principal investigator of a $1.44 million dollar "Population Health Data Initiative ("PHDI", supported by the UC Medical Center) to further advance population and health services research at UCSF. The goals of the 3-year project were to provide support for the institutional acquisition of several key data sources, establishment of a user-friendly data portal with capacity for data analytics to make these data accessible, as well as key investments to support junior faculty and trainees to use these data effectively.

IImmigrant and Latinx Health

My own qualitative and quantitative research has also examined health and economic disparities among multi-ethnic/racial groups nationally (e.g., health insurance coverage; risk taking behaviors, including teenage pregnancy, suicide, and substance use; and health outcomes). I have special expertise on diverse Latinx populations, global reproductive health, migration and health, as well as the impact of migration and acculturation on Latinx immigrants. For example, I completed a study with collaborators at UCLA and UCB focused on the health conditions and health care access of young Latinos eligible for health care as a result of the Deferred Action for Childhood Arrivals (DACA) program (often referred to as "Dreamers" in social media). On this project, I worked closely with a Latina Fellow in Adolescent Medicine and Health Policy (now a junior faculty member), a medical student in the joint UCB-UCSF Medical School program and hired several "Dreamers" to conduct the research. Results from this research (two briefs, 3 published articles) have been widely disseminated nationally, as well as serving as the basis for two briefings: one with state policymakers in Sacramento and the other with health providers and advocates. This data was used to support SB 4, which requires the provision of Medi-Cal (California's Medicaid Program) insurance coverage to undocumented children living in California, beginning in March 2016. Nearly 200,000 children and adolescents have benefited from the program.

I have also worked in the area of acculturation, social disparities, and health, including: 1) developing a research and policy agenda for cross-border health between Mexico and the U.S., 2) the impact of acculturation on the incidence of obesity among three different groups of Latinos—those born in Mexico who have immigrated to the U.S., Mexican-born populations that speak English, and U.S. born Mexicans who speak English, 3) the role of family planning as a means of reducing health disparities among Latinas, 4) risk and protective factors in adolescent pregnancy among adolescent and young adult Latinas, and 5) the challenge of measuring acculturation, particularly among Latinx adolescents.

Some of my co-authored relevant reports include: "Creating a Health Research and Policy Agenda for Im/migration Between Mexico and California", "Migration and Health: Mexican Immigrant Women in the U.S.," and "A Health Profile of Immigrant Teenagers", representing a multi-campus, cross-border collaboration between the National Population Council of the Government of Mexico (CONAPO), UCB School of Public Health Initiative of the Americas (ISA), UCLA School of Public Health, UC, Davis and UC Berkeley Migration and Health Research Center (MAHRC), and UCSF's Bixby Center for Global Reproductive Health (I am one of its Founding Directors). I have also collaborated on several projects focused on Latina youth, one of

which was converted into a 22-minute, award winning film, A Question of Hope, (http://nahic.ucsf.edu/multimedia/901/); (Spanish voice-over, Una Cuestión De Esperanza: Reduciendo los embarazos de adolescentes latinas en California (http://bixbycenter.ucsf.edu/videos/video-lo-3.html).

Adolescent Pregnancy Prevention and Reproductive Health Care Services Research

Over nearly 5 decades, I have conducted national and international research on teenage pregnancy prevention (as shown in my curriculum vitae). Pprojects have been funded by the State of California, Patient-Centered Outcomes Research Institute (PCORI), and the federal Office of Adolescent Health and Family and Youth Services Bureau. Specifically, I conducted evaluation research for the State that helps ascertain whether the state's investment is leading to positive outcomes, including a reduction in teenage pregnancy and fewer negative social and economic consequences. I served as Co-PI with Dr. Kathleen Tebb in a PCORI-funded grant entitled, Reducing Health Disparities in Unintended Pregnancies Among Hispanic Adolescents Using a Patient-Centered Computer-Based Clinic Intervention.

In another project, funded by the Federal Family and Youth Services Bureau (Dr. Mara Decker, Principal Investigator), we were evaluating the effectiveness of a Digital Initiative for Youth. This project represents an innovative youth-centered initiative to improve the sexual health and socio-economic well-being of youth in Fresno County, California, also using a newly developed app.(project was defunded in 2025 as a result of federal Executive Orders). Finally, I collaborated with Dr. Christine Dehlendorf,and Dr. Tebb, as we tested the use of social networks and their influence on encouraging adolescents to adopt the use of long-acting contraceptive methods (LARC). The project, entitled, SpeakOut: Empowering teen to teen communication about highly effective contraception, was also funded by the federal Office of Adolescent Health and is using app technology.

With colleagues at the National Family Planning and Reproductive Health Association and George Washington University, we conducted a 3-year study entitled, "Confidential and Covered: Protecting Patients While Preventing Revenue Loss". This study focused on developing and testing effective interventions that support the federal Title X Family Planning program's historic commitment to client confidentiality, while preventing and mitigating revenue loss at Title X service sites due to the provision of confidential services as part of health care reform efforts.

An area of related interest is the role of confidentiality, electronic health care records, and access to sensitive health services in the era of health care reform. Studies have included in-depth interviews with health professionals and stakeholders regarding options for reconciling the need for health insurance explanation of benefits requirements and the need for adolescents and young adults to access sensitive health services (Protecting Adolescent Confidentiality Under Health Care Reform: The Special Case of Explanation of Benefits (EOBs) (http://healthpolicy.ucsf.edu/Protecting-Adolescent-Confidentiality) and a policy analyses regarding the Electronic Health Care Record (Sensitive Health Care Services in the Era of Electronic Health Records: Challenges and Opportunities in Protecting Confidentiality for Adolescents and Young Adults - http://healthpolicy.ucsf.edu/sensitive-health-care-and-electronic-health-records). We also completed a California-focused study of the impact of insurance churning among young adults (https://cloudfront.escholarship.org/dist/prd/content/qt85g872v5/qt85g872v5.pdf?t=p60dow

Adolescent and Young Adult Health and Health Policy

With Dr. Charles Irwin (Director), I served as the co-Director of the Adolescent and Young Adult Health National Resource Center, funded by the federal Bureau of Maternal and Child Health. In this policy-practice endeavor, which was originally conceived by Dr. Irwin and me, was successfully funded between1999-2024, The Center aimed to promote adolescent and young adult (AYA) health by strengthening the abilities of State Title V MCH Programs, as well as public health and clinical health professionals, to better serve these populations (ages 10-25). Our work focused on increasing the receipt of quality preventive visits for AYAs, including . the establishment of AYAH Collaborative Improvement and Innovation Network (CoIIN) Projects. We used the CoIIN model to help selected states to address the well visit for adolescents and young adults. The CoIIN model, used by many states to address infant mortality, combined collaborative learning and quality improvement methods to drive a national strategy. As part of the Center, we conducted analyses of the health and well-being of adolescents and young adults, the impact of the ACA on this population, as well as studied ways to improve access to health insurance coverage and preventive health services. A final focus was on improving the numbers of states that promote young adult health (ages 18-25), including increasing their access to health insurance and preventive health care services.

I also conducted policy research and analyses of The Healthy People 2010 and 2020 Adolescent and Young Adult Health Objectives, and analyses of national data sets documenting the lack of health insurance among adolescents and young adults. As a result of the Affordable Care Act (ACA) and the expansion of Medicaid, disparities in access and utilization of services were reduced and increases in the use of mental health services were documented. This body of research (between 2006-2012) was the basis for bringing national attention to the needs of adolescents and young adults, specifically, the disparities they face in accessing health care, in particular for mental health services. In order to offer policy makers with a set of potential action steps, our team identified innovative programs aimed at: increasing the delivery of preventive mental health services for adolescents: assuring that insurance companies were developing products for young adults; and maximizing health insurance enrollment for young adults who represent 30% of the nation’s uninsured population. I completed one of the first studies of the ACA roll-out of health insurance coverage of young adults up to age 26 on their parent’s health insurance plans from the perspective of states (published in Journal of Health and Biomedical Law in Winter, 2015). We also conducted analyses of large national data sets to ascertain the impact of the ACA on young people’s access to health care and preventive health care visits. In 2006, our team received recognition for this body of work by the Society for Adolescent Health and Medicine (the Hilary E. Millar Award for Advancing the Field of Health Policy for Youth to the UCSF National Adolescent Health Information Center).

Health Services

With colleagues at UCSF, UC Berkeley, and UCLA, we assessed care integration (behavioral and primary care) in the California safety net within the context of the ACA, conducting a set of interrelated research projects to: 1) document the level of integration of care in the safety net system in California, including integration with specialists, ancillary services, hospitals, behavioral health, and social services; 2) evaluate efforts to support Medi Cal providers to adopt health information technology to facilitate functional integration; and 3) document the challenges encountered in outreach and enrollment for difficult to reach and enroll populations, including young men who previously were not eligible to receive subsidized health care. We have disseminated the findings to policy makers and stakeholders in California's health care safety net.

With colleagues at the Institute, we conducted a three-year evaluation of efforts to increase patient-centered care as part of the federal Center for Medicaid and Medicare Innovation Centers' endeavors. Funded by the Atlantic Philanthropies, the project entitled, the "Campaign for Better Care" (CBC), sought to engage vulnerable populations enrolled in public health plans to ensure that health reform measures reflected their needs, interests, and preferences. Three national advocacy organizations (Community Catalyst, the National Partnership for Women and Families, and PICO) developed models of consumer engagement in institutional decision-making. As part of the evaluation, the evaluation team developed a brief video to capture the voices of patients and providers, who share their stories about barriers in obtaining and providing health care. https://www.youtube.com/watch?v=TLveVpzP9cU

Community-Focused Early Childhood Development

With colleagues at UCSF Benioff Children's Hospital, Oakland and later at UCSF Medical Center, and funded by NextGen and the Benioff Foundation, we conducted an evaluation of a provider intervention aimed at reducing the word-gap between middle income and low-income children. Research has documented the dramatic difference between middle- and high-income households in which children 0-4 years of age are exposed to greater degrees of language interactions with their parents, as compared to low-income households, where less verbal stimulation contributes to a significantly limited vocabulary. The intent of this project was to educate low-income parents on the significant brain development that occurs very early in childhood and the importance of language interaction (singing, talking and reading) to close this existing word-gap that hampers future educational outcomes. Evaluation results documented the value of the health care provider in educating families regarding the importance of reading to their babies, as well as children.

Influence of the Sugar Industry on the Health of the Public

Over a period of 7 years, I worked with a team to bring greater attention to the impact of sugar on population health, beginning with a collaboration with Drs. Robert Lustig and Laura Schmidt and reflected in the article, "The Toxic Truth about Sugar". As part of our efforts, we established Sugar Science (http://sugarscience.ucsf.edu/, under the direction of Dr. Schmidt), and with the UCSF Library as a full partner, launched the Sugar Industry Library in Fall, 2018 (https://www.industrydocuments.ucsf.edu/food/), parallel to UCSF's renown Tobacco Industry Papers. This web-based resource, funded by the Arnold Foundation, is available to world-wide scholars interested in researching the impact of the food industry upon the nation's health, including the marketing of sugar-sweetened beverages leading to childhood obesity. A major symposium was held on November 15, 2018 to launch the archive (https://www.industrydocuments.ucsf.edu/research-tools/public-lectures/#food_unveiling).

Translating of Research into Policy

Underlying my research portfolio is an emphasis on the translation of research into policy, including not only publishing major research results in peer-reviewed journals, but also identifying different dissemination channels. For example, we published the cost-benefit analyses of the Family PACT program, helping to leverage over a billion dollars in California to serve low-income men, women, and adolescents. We also translated this research into easy to use formats for policy makers, including briefs for Congressional, as well as state Legislators. The briefs included data on the number of unintended pregnancies averted by their constituents, and the number of federal and state dollars averted through the prevention of those pregnancies. All of these dissemination and diffusion related efforts, along with my long standing research in

the area of maternal and child health, led to my co-chairing the Knowledge-Transfer Working group, as part of the Benioff-Gates $100 million dollar, ten-year commitment to reducing pre-term birth both in California and globally. Building on that experience, we evaluated the UCSF Preterm Birth Initiative-CA. The overall goal was to use evaluation findings to assess current programs and activities and offer insights into possible program modifications that could realign initiative strategies to ensure outcome achievement.

Reflecting upon the wide variety of research interests noted above, each has the theme of focusing on vulnerable and often marginalized populations, bringing the most comprehensive evidence to bear upon policy options, and engaging communities of stakeholders in identifying the most effective policy options available, given resources and evidence.

Separately, throughout my tenure at UCSF, I have been an advocate for health policy and highlighting the roles of our faculty in advancing health policy as they translate their research for a variety of policymakers. I led efforts to identify UCSF-wide faculty who have made a significant contribution and impact on health policy at the local, state, national and international level, as well as globally. These policy impacts reflect laws, regulations, and policies, as well as changes within clinical practices as a result of clinical guideline development. The project is entitled, Policy Champions and is available at *https://pophealth.ucsf.edu/champions/home*.

Adverse Childhood Experiences (ACEs) and adolescents/Latino youth

Along with colleagues Drs. Naomi Schapiro (School of Nursing) and Samira Soleimanpour, we wrote two concept papers for the Office of the California Surgeon General's (OSG) ACEs Aware Initiative. The first, *Screening adolescents for ACEs: Incorporating resilience and youth development*, addresses how to: ensure confidentiality in screenings; integrate ACEs screening into an assets-based, trauma-informed adolescent visit; and engage youth and families in active steps to mitigate impacts of ACEs and toxic stress. The second paper, entitled *Screening newcomer immigrant youth for ACEs: Adaptations to address language, literacy, stigma and caregiver support*, focuses on addressing cultural and structural barriers to disclosing trauma histories, language and literacy barriers, and challenges of maintaining confidentiality in small immigrant communities. It also addresses how to support resilience and youth development amid current legal and financial restrictions. As part of the research, we conducteda series of individual, zoom-based interviews with health professionals and conducted focus groups with adolescents. Results were used by the OSG to plan initiatives and staff capacity trainings
.

Rapid Assessment of COVID-19 Pandemic Indirect impacts and mitigating interventions

Given the dynamic nature of the COVID-19 pandemic and California's unfolding response, state decision makers required the capacity to anticipate which direct and indirect health impacts will prove especially costly over time and which interventions could mitigate the indirect adverse health outcomes for Californians and costs to the state. In close partnership with the Office of the California Surgeon General, senior IHPS faculty, staff and I worked to develop the "Rapid Assessment of Pandemic Indirect impacts and mitigating interventions for Decision-making" (RAPID) project. Its purpose was to provide timely economic analyses that aimed to support California state decision making on strategies to mitigate the mid- and long-term indirect health burdens of the COVID-19 pandemic, in the context of Adverse Childhood Experiences (ACEs), including [depression, homelessness and alcohol and opioid use]. "Indirect burden" refers to health harms not due to infection with the SARS-CoV-2 virus itself, but rather the biological impacts of the other stressors of the COVID-19 pandemic. This public anxiety regarding COVID-

19, compounded by the economic distress due to lost wages, employment, and financial assets; mass school closures; and necessary physical distancing measures was shown to result in an increase in stress-related morbidity and mortality. We completied an analysis highlighting major public health issues, illustrating our analytic approach and capability, identified data gaps, and promoted dialogue and feedback on ways that could further maximize the utility of the research for California policymakers (https://pmc.ncbi.nlm.nih.gov/articles/PMC9292069/).

Transition to Distinguished Professor (Emerita-on Recall)

As the Director of the Philip R. Lee Institute for Health Policy Studies for fourteen years (until July, 2020), I played a major leadership role within UCSF and the Institute in building strong research, methodological, and training capacity in the area of health outcomes research, population health, equity, and social determinants of health. This included monitoring the implementation of health care reform, among many pressing health topics, and building the next generation of health services and health policy talented faculty across our campus. I also recently led efforts to honor and celebrate the life of Philip R. Lee, who died on October 27, 2020. The film was presented on February 25th, 2021 and is available at: https://www.youtube.com/watch?v=JqcUeOHW9_Y.

In transitioning to this phase, I have been engaged in a variety of activities: as a Senior Advisor to the UC Center on Climate, Health and Equity, providing guidance to its two co-Directors as they have conducted their strategic plan, co-authored an article on decarbonization (https://academic.oup.com/healthaffairsscholar/article/1/1/qxad006/7203670, and worked with a Commonwealth Visiting Scholar, with whom we have written a manuscript, under review on the subject of implementing clinical decarbonization actions. I have also continued to serve as evaluator of the NIH-funded, UCSF Clinical and Translational Research Institute, evaluator of the UCSF ARCHES program, and serve as a co-investigator with an Adolescent Medicine faculty member, Dr. Jason Nagata, analyzing the impact of social media use on a variety of adolescent risk behaviors, including eating disorders, alcohol, drug use, and mental health issues. I also serve as a mentor to a variety of doctoral students, post-doctoral fellows, and junior faculty.

I served on the National Academy of Science, Engineering and Medicine, National Research Council's Governing Board (4 years;2020-2024), as Vice-Chair of the NAM Council for 3 years (2020-2023), and as Chair of the Advisory Board for the Division of Social and Behavioral Sciences and Educational Studies (2025-present). I chaired the Search Committee for the next President of NAM (2024-2025).

RESEARCH AWARDS – CURRENT
Title: UCSF-Kaiser Building Interdisciplinary Research Careers in Women's Health Program

* Major Goals: The goal of the UCSF/Kaiser BIRCWH program is to increase the number, quality, and breadth of women's health researchers. We aim to facilitate the career development of outstanding independent investigators experienced in multidisciplinary, translational, and clinical women's health research.

  Project Number: 8 K12AR084219-26; Source of Support: NIH NIAMS

*Status of Support: Project/Proposal Start and End Date: 09/2000 - 04/2025; PD/PI: Brindis, Claire/Harper, Cynthia (MPI);(Total Award Amount (including Indirect Costs): $3,811,838 for 08/2020 – 04/2025 cycle).Active (*awaiting renewal 5/1/2025-2030*);.60 effort;

* **Title: UCSF Clinical and Translational Science Institute (CTSI)**
* Major Goals: The UCSF Clinical and Translational Science Institute (CTSI) has built a coordinated platform for clinical and translational research, successfully improved, integrated, and extended research services and infrastructure, and created comprehensive training programs. The program has expanded services and infrastructure by collaborating with regional partners, notably the 5 University of California CTSAs (UC BRAID), and measurably improved the health of vulnerable residents in the San Francisco Bay Area. Building on this foundational work, the CTSI now proposes to leverage these strengths by developing and linking emerging technologies to improve the quality, efficiency, and cost of conducting interdisciplinary, multisite clinical and translational research.
* Status of Support: Active Project Number: UL1TR001872; PD/PI: Collard, H.; Nguyen, T. Jacoby, V.(MPI); Source of Support: NCATS; Project/Proposal Start and End Date: 07/2021 - 06/2026; Total Award Amount (including Indirect Costs): $42,460,585; Person Months (Calendar/Academic/Summer) per budget period. 1.20 calendar per year (2025;2026).

Title: Leadership Training in Adolescent Health

Major Goals: The goals and objectives are to: 1) Recruit and train trainees to become AYA health leaders across the 5 core MCH disciplines & Public Health who can improve the quality of care and equitable access to services; (2) Develop & implement an interdisciplinary leadership curriculum; (3) Strengthen the capacity of clinical and non-clinical systems to improve AYA health through coordination and collaboration of technical assistance (TA), continuing education (CE), using technology and expanding partnerships with systems that care for underserved AYAs; (4) Advance delivery of equitable evidence-based health care to AYAs through: building trainees' skills in delivering quality clinical care to diverse AYA populations; enhanced engagement with communities & collaboration with institutions that serve AYAs; and addressing emerging issues.

* Status of Support: Active Project Number: T71MC00003-46; PD/PI: Irwin, Charles; Source of Support: PHS Health Resources & Services Admin; Project/Proposal Start and End Date: 07/2023 - 06/2027; Total Award Amount (including Indirect Costs): $1,837,480; Person Months (Calendar/Academic/Summer) per budget period..30 (2025); .60 (2026); .60 (2027)

Title: Investigating relationships between problematic social media use and binge-eating disorder to inform precision guidance for adolescents

Major Goals: To identify important interrelations among problematic social media use patterns and binge-eating disorder, using novel measures, prospective data, and machine learning methods on a large national cohort to inform tailored clinical and public health interventions.

* Status of Support: Active Project Number: R01 MH135492-01 PD/PI: Nagata, Jason; Source of Support: NIMH; Project/Proposal Start and End Date: 09/2023 - 06/2028; Total Award Amount (including Indirect Costs): $2,945,079 (.60 Person Months for 2025-2028).

PENDING

* **Title: Longitudinal pathways between adolescent social media use and substance use: Informing evidence-based guidance**
* Major Goals: To examine how social media use during adolescence may contribute to early substance use, such as nicotine, cannabis, and alcohol use. We will also examine parenting

rules and monitoring that may protect from substance use.

Status of Support: Pending Project Number: R01DA064134; PD/PI: Nagata, Jason; Source of Support: NIH NIDA; Project/Proposal Start and End Date: 07/2025 – 06/2030; Total Award Amount (including Indirect Costs): $3,802,799; Person Months (Calendar/Academic/Summer) per budget period. (.30 for 2026-2027).

Title: University of California, San Francisco/Kaiser Permanente Northern California Division of Research Building Interdisciplinary Research Careers in Women's Health (BIRCWH) K12 Program

* Major Goals: This competing renewal application is to support the University of California, San Francisco (UCSF) and Kaiser Permanente Northern California (KPNC) Division of Research's Building Interdisciplinary Research Careers in Women's Health (BIRCWH) Program. The program objectives are to: Recruit a superb group of early-career women's health researchers; provide tailored training and mentoring on sex and gender influences in health and disease; build upon our existing program by targeting topics in women's health of public health importance; strengthen and integrate models of interdisciplinary research to develop researchers who foster linkages across disciplines and institutions and excel in building team science; and to promote the prominence of women's health and the retention of investigators underrepresented in clinical research by mentoring BIRCWH scholars and alumni in academic advancement and leadership.

Name of PD/PI: Harper, Cynthia/Gandhi, Monica (MPI); Source of Support: NIH/NIAMS

Project/Proposal Start and End Date: 05/2025 – 04/2030; Total Award Amount (including Indirect Costs): $4,537,516; .60 for 2026-2030).

* **Title: Informing guidance on social media use to reduce depression and anxiety in adolescents**

* Major Goals: To explore temporal and bidirectional associations between digital media engagement and internalizing symptoms of anxiety and depression in adolescence, while identifying multilevel protective factors (individual, relational, and contextual) that buffer against negative mental health outcomes.
* Status of Support: Pending Project Number: R01MH138986; PD/PI: Nagata, Jason
* Source of Support: NIH NIMH; Project/Proposal Start and End Date: 12/2025 – 11/2030
* Total Award Amount (including Indirect Costs): $3,723,183; Person Months (Calendar/Academic/Summer) per budget period .60 for 2026-2030.

***Title: UCSF Clinical and Translational Science Institute**
*Major Goals: The mission and vision of the University of California, San Francisco's Clinical and Translational Science Institute (CTSI) is to accelerate research to improve health by creating and fostering a transdisciplinary clinical and translational science environment in collaboration with, and embracing scientific and community stakeholders.
*Status of Support: Pending
*Project Number: UM1TR006119 PD/PI: Jacoby, Vanessa L, MD (contact)/Collard, Hal/Kanaya, Alka
*Source of Support: NIH Natl Ctr Advancing Translational Sci(NIH-NCATS)
*Project/Proposal Start and End Date: 07/01/2026 – 12/31/2035
*Total Award Amount (including Indirect Costs): $74,619,040

Prepared: July 2, 2025

* Person Months (Calendar/Academic/Summer) per budget period: 1.2 for 2026-2035

COMPLETED PROJECTS

1.	2002-7925/99-3654	PI		
	The William and Flora Hewlett Foundation		7/1/1983	6/30/2005
	William and Flora Hewlett Fellowship in Latin American Reproductive Health Policy		$ 55,302 direct/yr 1	$ 705,943 total
2.	04-35976	PI		Brindis (PI)
	California Department of Public Health		07/01/1997	06/30/2015
	Teen Pregnancy Prevention Project Evaluation		$ 1,312,800 direct/yr 1	$ 6,918,905 total
	Evaluation research that help characterize the funded programs and estimate how well they are meeting the State's objectives. Program evaluation results help public health professionals, educators, and policymakers to support more effective teenage pregnancy prevention interventions to reduce the negative social and economic consequences of this important public policy issue.			
3.		PI		
	The California Wellness Foundation		10/01/1997	06/30/2007
	Evaluation of The California Wellness Foundation's Teen Pregnancy Prevention Initiative		$ 190,887 direct/yr 1	$ 627,011 total
4.	C2004-501/4375	PI		Brindis (PI)
	Alameda County Department of Health Services		07/01/1998	06/30/2012
	Evaluation of the Alameda County School-Based Health Care Network		$ 62,834 direct/yr 1	$ 716,646 total
	The study aims to document the SHS programs' impact on students' access to and utilization of health care, and improvements in their health status and behaviors			
5.	35038-OS-332	PI		
	Centers for Disease Control (CDC		07/01/2000	12/01/2003
	Evaluation of the CDC's Teenage Pregnancy Prevention Initiatives, subcontract to MACRO International		$ 100,000 direct/yr 1	$ 281,990 total
6.		PI		
	Johnson and Johnson Foundation		06/01/2002	09/01/2004

	Evaluation of the National Center for Excellence in Women's Health University of California, Community Women Leadership Projects		$ 70,000 direct/yr 1	$ 145,000 total
7.	20021734	PI		
	The California Endowment		06/01/2002	06/30/2005
	Evaluation of the Community Clinic Consortia Policy Initiative		$ 100,000 direct/yr 1	$ 900,000 total
8.		PI		
	Johnson and Johnson Foundation		06/01/2002	06/01/2005
	Evaluation of the Bridges to Employment- Milpitas High School		$ 32,000 direct/yr 1	$ 90,000 total
9.		PI		
	Johnson and Johnson Foundation		06/01/2002	06/30/2005
	Evaluation of the San Jose Nursing Academy		$ 15,000 direct/yr 1	$ 45,000 total
10.	R06-CCR921786-0	PI		
	Center for Disease Control and Prevention, Department of Health and Human Services		09/01/2002	04/01/2005
	Participatory Research in School-Based Health Center Research		$ 27,296 direct/yr 1	$ 818,896 total
11.		PI		
	Federal Health and Human Resources Administration		10/01/2004	09/30/2005
	Adolescent Health Program Evaluation		$ 250,000 direct/yr 1	
12.	2008-12211	PI		Brindis (PI)
	The California Endowment		02/01/2006	06/30/2012
	Health Journalism Fellowship Evaluation			$ 90,037 total
	Fellowship program to teach journalists to examine and report on the nuances of health care issues for multicultural populations, with a special emphasis on health disparities, its impact on health care access and the quality of services available.			
13.	2008-2211	PI		
	California Endowment		2/01/2006	9/30/2015

Health Journalism Fellowship Evaluation $ 300,000 total

14. 1329AFK-ESP-2006 PI Brindis (PI)
US Department of Public Health, Office of Population Affairs (Subcontract) / CDC 09/01/2006 09/01/2012
Evaluation of La Clinica de la Raza, Inc. $ 281,955 direct/yr 1 $ 750,000 total
A multi-year, longitudinal, randomized evaluation of 'group prenatal care' visits for pregnant and parenting adolescents vs. traditional prenatal care services is being conducted, including quantitative and qualitative methods

15. 1013139 PI Brindis (PI)
Public Health Institute (subcontract) / CDC (Prime) 03/01/2007 09/29/2012
Reducing Asthma Disparities through Comprehensive, Community Activities $ 93,985 direct/yr 1 $ 469,925 total
This evaluation is tracking and monitoring a variety of community-based strategies aimed at reducing health disparities that result in the worsening of asthma health outcomes. Interventions being tested include evaluations of community-based coalitions, environmental strategies, and policy-focused advocacy activities.

16. Co-PI
The California Endowment and the California Healthcare Foundation 07/01/2007 08/01/2008
Developing a Latino/a Research and Program Agenda on Translational Health, with Global Health Sciences $ 150,000 direct/yr 1

17. MCHB T71MC0003L Co-PI Irwin (PI)
Maternal and Child Health Bureau, Health Resources and Services Administration, Department of Health and Human Services Maternal and Child Health Bureau, U.S. Department of Health and Human Services 07/01/2007 06/30/2014
Interdisciplinary Leadership Education in Adolescent Health, Public Policy Analysis and Education Center for Middle Childhood Adolescent Health, and the National Adolescent Health Information Center $ 1,449,231 total
Conduct policy analyses and research pertaining to adolescent health.

18. 2008-2092 PI
The William and Flora Hewlett Foundation 02/01/2008 06/30/2011

	Common Ground, Common Goals: The Juncture of Schools and Health in Securing California's Future		$ 150,000 total

19. 20081465 PI Brindis (PI)

The California Endowment	10/01/2008	1/31/2012
Evaluation of Statewide Burden of Asthma	$ 156,521 direct/yr 1	$ 547,934 total

This evaluation assesses the impact of consortia in impacting policy in the area of environment, schools and homes. Coalition surveys, policy maker interviews, and pre and post data are being used.

20. 20081866 PI Brindis (PI)

The California Endowment	01/01/2009	12/31/2011
Community Action to Fight Asthma Legacy; Statewide Asthma Initiative		$ 156,521 total

This project analyzes the outcomes and lessions learned on the seven year initiative to create policies to reduce the environmental risk factors that affect asthma for school-aged youth. Policy change and policy advocacy occurred at the local, regional, and state levels and focused on policies related to housing, schools, and outdoor air.

21. FPR PA006051 Co-PI Darney (PI)

Department of Health and Human Services Office of Population Affairs	09/01/2009	08/31/2014
Innovative Evaluation of Title X and 1115 Waiver Family Planning Program	$ 100,000 direct/yr 1	$ 476,176 total

Provide conceptual guidance to the development of project design and methodology and oversight of project planning and implementation.

22. PI Brindis (PI)

The Colorado Health Foundation	03/01/2010	12/31/2013
School Based Health Care Initiative Evaluation	$ 96,699 direct/yr 1	$ 290,007 total

Quantitative and qualitative methods are used to evaluate the Colorado Health Foundation’s $10.8 million School-Based Health Care Initiative’s processes, assess factors that contribute to school-based health care program sustainability, and identify best practices to guide operations of current and future school-based health care programs.

23. 2010-066 PI Brindis (PI)

The California Wellness Foundation	07/01/2010	03/31/2015

Assessing the Impact of Federal and State Cuts on California's Teenage Pregnancy Prevention Programs — $ 400,00 total

This study examines how state budget cuts that have resulted from the national and state recession have impacted the California programs and service providers devoted to the needs of youth at high risk of becoming pregnant for the first time and teen parents at risk for repeat pregnancy.

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24. 639265-10S-1525 — PI — Brindis (PI)

ICF MACRO (Atlantic Philanthropy subcontract) — 7/01/2010 — 12/31/2015

ICF Macro — $ 495,123 total

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25. 05-45221 — Co-PI — Darney (PI)

State of California, Office of Family Planning — 07/01/2010 — 06/30/2015

Evaluation of the Family PACT (Planning, Access, Care and Treatment) Program — $ 2,199,084 direct/yr 1 — $ 11,717,235 total

This evaluation of the states' comprehensive family planning program includes billing data analyses, focus groups with providers and clients, exit interviews, cost-benefit analyses, and case studies

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26. P60MD006902 — Co-Investigator — Bibbins-Domingo (PI)

NIMHD — 08/27/2012 — 02/28/2018

Comprehensive Centers of Excellence Addressing Disparities in Chronic Disease with a Teen and Young Adult Focus — $ 779,767 total

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27. 21663 — PI — Brindis (PI)

The Atlantic Philanthropies — 01/01/2013 — 12/31/2015

Philip R. Lee Institute for Health Policy Studies' Campaign for Better Care Evaluation — $ 1,200,000 total

To conduct an evaluation of the effectiveness of consumer mobilization in affecting health care system redesign and improving health outcomes for vulnerable older adults.

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28. 8731749 — Co-PI — Grumbach/Brindis (PI)

Blue Shield Foundation — 7/1/2013 — 6/30/2014

Assessing care integration in the California safety net — $ 41,120 total

conducting a set of interrelated research projects to: 1) assess the level of integration of care in the safety net system in California, including integration with specialists, ancillary services, hospitals, behavioral health, and social services; 2) assess efforts to support MediCal providers to adopt health information technology to facilitate functional integration; and 3) disseminate the findings to policy makers and stakeholders in California's health care safety net.

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29. Co-PI — Brinids/Roby (PI)

Packard Foundation — 07/01/2013 — 1/31/2018

California Children's Services Evaluation — $ 347,986 total

An evaluation of California's Enhanced Primary Care Case Management (EPCCM) Program, the Provider-based Accountable Care Organization (ACO); Specialty Health Care Plan (SHCP); and utilization of existing Medi-Cal Managed Care Plans.

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30. PI — Brindis (PI)

The World Bank — 9/1/2013 — 1/31/2014

Teen Pregnancy Prevention Evaluation and Technical Assistance — $ 95,000 total

To provide training and technical assistance to family planning agencies, as well as monitor and evaluate the process and outcomes of the programs, as well as make recommendations regarding World Bank investments in Ethiopia and Nepal.

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31. 07-65654 PI — Brindis (PI)

California Department of Public Health, Maternal, Child and Adolescent Health — 12/01/2013 — 11/30/2015

Building Capacity to Advance the Health & Well-being of Adolescents — $ 1,462,687 total

To provide information, resources and expertise to support the provision of quality health care services to adolescents, increase the capacity of local Maternal, Child and Adolescent Health (MCAH) jurisdictions and their adolescent health practitioners to promote the health of adolescents, and to influence policy with the intent of improving the health and well-being of California's adolescents.

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32. Co-PI — Jacobs/Brindis (PI)

Blue Shield Foundation-Subcontract — 07/01/2014 — 3/30/2016

Medi-Cal Eligible but not Enrolled, Remaining uninsured in California: Qualitative and Quantitative Study of Deferred Action Childhood Arrivals (DACA) — $ 40,999 total

Subcontract with UC Berkeley Labor Center. This project, bringing researchers from the UCLA Center for Health Policy, UC Berkeley, and UCSF, is analyzing California Health Interview Survey Data, as well as conducting 9 focus groups with Latino DACA-Eligible young adults. Study sites include Los Angeles and San Francisco Bay Area. Recruitment is being conducted by Dreamers and through a variety of social media channels.

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33. PI — Brindis (PI)

Alameda County — 7/01/2014 — 6/30/2015

Alameda County School Health Services Evaluation — $ 325,000 total

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34. PI — Brindis (PI)

National School Based Alliance — 8/01/2014 — 8/30/2015

Evaluation of School Based Health Services — $ 110,000 total

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35. Co-PI — Brindis (PI)

Next Generation (Benioff Foundation) — 9/01/2014 — 8/30/2017

Evaluation of "Too Small to Fail" — $ 850,000 total

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36. Co-PI — Brindis (PI)

National Family Planning and Reproductive Health Association — 9/1/2014 — 8/30/2017

Confidential and Covered: Protecting Patients While Preventing Revenue Loss

This national, multi-site project, funded by the federal Office of Population Affairs, will develop and test interventions that support the federal Title X Family Planning program’s historic commitment to client confidentiality, while preventing and mitigating revenue loss at Title X service sites due to the provision of confidential services as part of health care reform efforts

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37. NU38PS004649 — Co-I — Kahn (PI)

US Centers for Disease Control and Prevention, Department of Health and Human Services — 9/30/2014 — 9/29/2019

Economic Analysis for Prevention of Disease (EMPoD) — $ 4,855,069 total

The overall goal is to support the prevention effectiveness of state and local public health jurisdictions by providing scientifically valid economic modeling tools populated with setting-relevant data.

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38. PI — Brindis (PI)

California HealthCare Foundation — 10/01/2014 — 12/31/2014

Evaluation of Health Reporting Project $ 21,000 total

39. 15-10047 PI Brindis (PI)
California Department of Public Health 07/01/2015 06/30/2018
Teen Pregnancy Prevention Project Evaluation $ 4,842,846 total
Evaluation research that help characterize the funded programs and estimate how well they are meeting the State's objectives. Program evaluation results help public health professionals, educators, and policymakers to support more effective teenage pregnancy prevention interventions to reduce the negative social and economic consequences of this important public policy issue.

40. SC15-1502-27481 Co-Investigator Tebb (PI)
Patient-Centered Outcomes Research Institute 12/01/2015 11/30/2018
Reducing Health Disparities in Unintended Pregnancies Among Hispanic Adolescents Using a Patient-Centered Computer-Based Clinic Intervention $ 548,885 total
The major goals of this project are (1) support the adolescents in making decisions about an effective method of contraception by increasing knowledge and self-efficacy; (2) improve the effectiveness and efficiency of the clinical encounter; and (3) reduce the incidence of unprotected sexual intercourse among Latina adolescents girls over time.

41. PI Brindis (PI)
Programa de Investigacion en Migracion y Salud (PIMSA) 09/01/2016 02/28/2018
Bi-National Perspectives on Adolescent Childbearing, Obesity, Diabetes and Cesarean Sections $ 30,000 total

42. 20094 PI Brindis (PI)
California HealthCare Foundation 03/01/2017 02/28/2018
UCSF/Hastings Speakers Series: ACA Potential Impact of the Trump Administration on Health Policy $ 97,000 total

43. PI Brindis (PI)
Laura and John Arnold Foundation 12/01/2017 11/30/2019
Launching the Digital Food Industry Documents Archive $ 1,603,712 total
To launch a new Food Industry Document Archive in UCSF's digital Industry Documents Library (IDL) and develop a longer-term plan to continue to build the collections.

44. TP2AH000045 Co-PI Dehlendorf/Brindis (PI)
Department of Health and Human Services, Office of Adolescent Health 07/01/2015 06/30/2020
SpeakOut: Empowering teen to teen communication about highly effective contraception
The major goals of this project are to conduct rigorous evaluation of new or innovative approaches to prevent teen pregnancy.

45. SC15-1502-27481 Co-Investigator Tebb (PI)
Patient-Centered Outcomes Research Institute 12/01/2015 11/30/2020
Reducing Health Disparities in Unintended Pregnancies Among Hispanic Adolescents Using a Patient-Centered Computer-Based Clinic Intervention $ 548,885 total
The major goals of this project are (1) support the adolescents in making decisions about an effective method of contraception by increasing knowledge and self-efficacy; (2) improve the effectiveness and efficiency of the clinical encounter; and (3) reduce the incidence of unprotected sexual intercourse among Latina adolescents' girls over time.

46. 2020-21-OSG Co-PI Brindis/ Malekinejad (PI)
Office of the California Surgeon General 9/1/2020 3/31/2021
Rapid Assessment of Pandemic indirect impacts and mitigating interventions for Decision-making in California (RAPID) $ 456,278 total
The goal of this project is provide analysis on high-burden short-term adverse health conditions that are not the direct medical effects of the novel coronavirus (e.g., death or hospitalization due to COVID-19 or worsening comorbidities). As the pandemic unfolds, we anticipate increases in the incidence (or recurrence/exacerbation) of a wide range of behavioral and mental health conditions (e.g., anxiety, depression, PTSD-like syndrome, suicide, alcohol and substance abuse) and physical health problems (e.g., cardiovascular diseases, metabolic disorders, maternity problems).

47. R01HL129288 Co-Investigator Patel (PI)
NIH/NHLBI; Stanford University 4/1/2016 5/31/2022
Impact of Water Access on Child Food and Beverage Intake and Obesity $ 3,749,891 total
The project examines how promoting fresh water intake, both in schools that do and do not provide access to caloric beverages impacts children's consumption of food and beverages both during and outside of school, and obesity.

48. None | PI | Brindis (PI)
Aurrera Health Group | 6/30/2020 | 12/31/2021
ACES Aware Provider Engagement Grant | $ 100,000 total
The goal of this project is to develop and disseminate two white papers widely to adolescent health, family health, and social services providers via email distribution lists, research sites, web platforms, social media and conference presentations.

49. 90AP2688 | Co-PI | Decker/Brindis (PI)
Family and Youth Services Bureau | 9/1/2016 | 3/29/2022
Digital Initiative for Youth (DIY) | $ 3,749,891 total
An innovative youth-centered initiative to improve the sexual health and socio-economic well-being of youth in Fresno County, California

50. | PI | Brindis (PI)
Benioff Foundation | 3/1/2017 | 9/30/2021
The California Preterm Birth Initiative | $ 463,131 direct/yr 1
The overall goal is to use evaluation findings to assess current programs and activities and offer insight into possible modifications that could realign initiative strategies to ensure outcome achievement.

51. 18-10026 | Co-PI | Decker/Brindis (PI)
California Department of Public Health | 7/1/2018 | 6/30/2021
Adolescent Health Evaluations | $ 1,800,000 total
The purpose of the Adolescent Health Programs is to utilize effective, evidence-based or evidence-informed approaches and strategies to reduce rates of adolescent birth, repeat adolescent births and sexually transmitted infections among high-need youth populations. In addition, promote protective factors and build resilience strengths, assist program participants in accessing needed services, and build models for successful adolescent health programming to improve the health and well-being of California's adolescents.

52. 29-312-0214448-65402 | Co-PI | Gottlieb/Brindis (PI)
RTI International | 09/17/2018 | 09/30/2019
Accountable Health Communities (AHC) - Evaluation
The purpose of this project seeks to test the efficacy of Assistance Track and Alignment Track models in reducing per-patient spending and inappropriate utilization and improving health outcomes.

53. No grant # (Brindis) | Co-PI | Brindis/Spetz (PI)
UCSF Strategic Initiatives | 07/01/2019 | 6/30/2022

Infrastructure to advance health services research at UCSF $ 1,446,945 total

The goal of this project is to expand the capacity to jumpstart the career of young investigators interested in building a Health Services Research (HSR) career at UCSF through increasing the acquisition, visibility and use of needed data sets and analytics that will lead to increased opportunities and collaborations across UCSF and UC Health, leading to a greater impact of the UCSF HSR community both here and nationally.

54. Title: Alameda County School Health Centers Evaluation
Major Goals: Evaluation of the Alameda County School Health Services (SHS) Coalition's school-based health centers and school-based behavioral health services, including documenting impact on students' access to and utilization of health care, and improvements in their health status and behaviors.
Project Number: 15388
Name of PD/PI: Brindis, Claire
Source of Support: Alameda County Health Care Services Agency
Project/Proposal Start and End Date: (7/1/2017 - 6/30/2022
Total Award Amount (including Indirect Costs): $1,675,000

55. Title: ACES Aware Provider Engagement Grant
Major Goals: The goal of this project is to develop and disseminate two white papers widely to adolescent health, family health, and social services providers via email distribution lists, research sites, web platforms, social media and conference presentations.
Project Number: N/A
Name of PD/PI: Brindis, Claire and Soleimanpour, Samira and Schapiro, Naomi
Source of Support: Aurrera Health Group
Project/Proposal Start and End Date: 6/30/2020 - 12/31/2021
Total Award Amount (including Indirect Costs): $100,000

56. Title: State Adolescent and Young Adult Health Capacity Building Program
Major Goals: To enhance knowledge and inform practices of professionals and policy- and decision-makers regarding the consequences of public policies on young people, including analyzing the effects of public policies, regulations and practices at the community, state and federal levels on the health of young people and formulating policy options and develop model public policies.
Project Number: 2 U45 MC 27709-07-00
Name of PD/PI: Irwin, Charles
Source of Support: NIH NIDA
Project/Proposal Start and End Date: (MM/YYYY) (if available): 9/1/2014 - 8/31/2023
Total Award Amount (including Indirect Costs): $5,750,000 for Years 5-9 cycle.

57. Title: Promoting Optimal Health for Rural Youth
Major Goals: This project partners with Fresno Economic Opportunities Commission and Fresno County Superintendent of Schools to promote the optimal health of youth in rural Fresno County and reduce unintended pregnancies.
Project Number: 1 TP1AH000233-01-00
Name of PD/PI: Decker, Mara

Source of Support: PHS Office of Population Affairs
Project/Proposal Start and End Date: (MM/YYYY) (if available): 7/1/2020 - 6/30/2023
Total Award Amount (including Indirect Costs): $2,570,554

58. Title: Implementation of Health-E You/Salud iTu to Promote Adolescent-Centered Contraceptive Care
Major Goals: The major goals of this implementation study is 1) to facilitate and understand the adoption of the Health-E you/Salud iTu intervention by providers in a vast network of SBHCs serving adolescents from diverse backgrounds in multiple states across the U.S. and and 2) to assess improvements in contraceptive use associated with our implementation study.
Project Number: DI-2020C2-2037; PD/PI: Tebb, Kathlee; Source of Support: Patient Centered Outcomes Research Institute (PCORI);Project/Proposal Start and End Date: 7/1/2021 - 6/30/2025; Total Award Amount (including Indirect Costs): $1,401,546.

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142. **Brindis CD**. More Access to Health Care: Opportunities for Leadership in Value, Quality and Equity. Journal of the San Francisco Marin Medical Society. March, 91(2). 2018

143. Schapiro NA, Soleimanpour S, **Brindis CD**. Reaching Out to Youth about Trauma: Adolescent Rapid Screening Validation Pilot. Platform Abstracts. Journal of Adolescent Health 62:S1–S19. 2018

144. **Brindis CD**, Decker M, Gutman-Gonzalez A, Lanshaw N, Corsack C. Advancing Health Equity and Justice in California: A Landscape Analysis. Submitted to Hispanics in Philanthropy. https://hiponline.org/wp-content/uploads/2018/11/HIP-Taking-a-Pulse_web.pdf. July, 2018

145. Po J, **Brindis CD**, Adams S, Teipel K, Park MJ, & Sieving R. Improving Young Adult Health: State & Local Strategies for Success. San Francisco, CA: National Adolescent and Young

Adult Health Information Center, University of California, San Francisco; 2020. Available at: https://nahic.ucsf.edu/resource_center/ya-strategies/

146. **Brindis CD**, Mohsen M, Kahn, JG, Schmidt, L, et. al "Rapid Assessment of Pandemic Indirect Impacts and Mitigating Interventions for Decision-making" (RAPID), Final Report Submitted to the Office of the California Surgeon General, Sacramento, Ca. March 17, 2021.

147. University of California, San Francisco; University of Minnesota. Promoting and caring for Young Adult mental health: Challenges and Opportunities for Improvement, University of California, February 2023. https://nahic.ucsf.edu/resource_center/promoting-and-caring-for-young-adult-mental-health-challenges-andopportunities-for-improvement/

148. Adams SA, Park MJ, Brindis CD, Irwin CE, Jr. Sources of Preventive Visit Data for Adolescents and Young Adults. (2023). National Adolescent and Young Adult Health Information Center; San Francisco. Available from: https://nahic.ucsf.edu/sources-of-preventive-visitdatafor-adolescents-and-young-adults

SIGNIFICANT PUBLICATIONS

1. Amaral G, Foster D, Biggs MA, Jasik C Judd S, **Brindis CD**. Public savings from the prevention of unintended pregnancy: A cost analysis of family planning services in California. Health Services Research. Vol. 42(5) 1960-1980, 2007. http://www.hsr.org/hsr/abstract.jsp?aid=42386172996

   This paper was written collaboratively, building upon methodology that Dr. Brindis had established and developed previously to support the awarding of an 1115 Medicaid Demonstration Waiver to support subsidized family planning services for low income women and men up to 200% of poverty living in California. The analysis has been used successfully to justify federal investments in the state that have reached over a $1.5 billion dollars. Dr. Brindis helped to supervise the writing of the paper, wrote sections of the discussion, and oversaw revisions and resubmission.

2. Kreger M, Sargent K, Arons A, Standish M, **Brindis CD**. Creating an Environmental Justice Framework for Policy Change in Childhood Asthma: A Grassroots to Treetops Approach. American Journal of Public Health. 2011. Vol. 101, S1 208-216. http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2011.300188

   Dr. Brindis was Principal Investigator for the evaluation of The California Endowment's Asthma Initiative, which is the basis for this paper. Dr. Brindis contributed to the conceptual framework of the research, conducted analyses, as well as preparation of the manuscript.

3. Raymond-Flesch M, Siemons R, Pourat N, Jacobs K, **Brindis CD**. "There Is No Help Out There and If There Is, It's Really Hard to Find": A Qualitative Study of the Health Concerns and Health Care Access of Latino "DREAMers." Journal of Adolescent Health, Sept. 2014,55(3):323–328. 2014.

   This paper summarizes the first qualitative study of Deferred Action for Childhood Arrivals in the U.S. Dr. Brindis was co-investigator for this study, conceived the research design, conducted focus groups, directed the analyses, and collaborated in writing the manuscript, including overseeing revisions and resubmission.

4. **Brindis CD**, Freund KM, Baecher-Lind L, et. al. The Risk of Remaining Silent: Addressing the Current Threats to Women's Health. Women's Health Issues. 2017 Nov - Dec; 27(6):621-624.

   This paper is an analyses of policy issues that have emerged as a threat to women's health and well-being under the Trump Administration. Dr. Brindis wrote the paper, as well as brought together a number of key leaders in women's health to discuss the myriad women's health issues at risk of being upended.

5. Adams S, Park MJ, Twietmeyer L, **Brindis CD**, Irwin CE Jr. Association between Adolesce Preventive Care and The Role of the Affordable Care Act. JAMA Pediatr,. 2018;172(1):43-48. doi:10.1001/jamapediatrics.2017.3140

   This paper is the first nation-wide analysis of the effect of the ACA on improving the content of preventive care services on adolescents over the past four years. I collaborated with my colleagues to conceptualize the hypotheses, assisted in reviewing the overall analyses of the data, and provided input into the final editorial work for submitting this paper.

CONFERENCE ABSTRACTS (Representative Sample)

1. Eliminating Health Disparities by Increasing Access to Family Planning Services: California's Family PACT Program. (Presented with A. Biggs, G. Amaral, DG. Foster, H.T. de Bocanegra), AcademyHealth, Orlando, FL.
2. Cost effectiveness of Chlamydia control services among family planning clients. (Presented with M.A. Biggs, D. Greene Foster, J. Chow, G. Amaral), American Public Health Association, Washington, DC.
3. Cost effectiveness of advance provision of emergency contraception. (Presented with D. Greene Foster, T. Raine L. Cao, D.P. Rostovtseva, P. Darney), American Public Health Association, Washington, DC.
4. Cost effectiveness of advance provision of emergency contraception.(Presented with T. Raine, L. Cao, D.P. Rostovtseva, P. Darney), American Public Health Association, Washington, DC.
5. Cost savings from the provision of specific methods of contraception. (Presented with D. Greene Foster, M.A. Biggs, G. Amaral, H. T. de Bocanegra, D.P. Rostovtseva, P. Darney), American Public Health Association, Washington, DC
6. Bringing teens into the family planning clinic: The importance of diverse outreach strategies.(Presented with A. Arons, L. Ralph, N. Berglas, M.A. Biggs), American Public Health Association, Washington, DC.
7. Creating youth friendly clinics: Findings from California Case studies. (Presented with L .Maddock, S. Koenemann, S. Hunter), American Public Health Association, Washington, DC.
8. Teens reaching teens: Use of peer outreach workers in family planning clinics. (Presented with N. Berglas, A. Arons, L. Ralph, M.A. Biggs), American Public Health Association, Washington, DC.

9. Finding teens in TheirSpace: Using internet social networking sites to increase access to family planning. (Presented with S. Schwartz, L. Ralph, N. Berglas).American Public Health Association, San Diego, CA.
10. Teen Births Up, but We're Not Down: Why Age Matters When It Comes to Contraception. (Presented with S. Koenemann), American Public Health Association, San Diego, CA.
11. Pregnancy intendedness and decision-making among young Latinas: Findings from a qualitative study. (Presented with S. Schwartz, L. Ralph, M .A. Biggs, A. Arons), American Public Health Association, San Diego, CA.
12. Accidents Do Happen: Emergency Contraceptives, Teen Contraceptive Use and Knowledge of Reproductive Health Services. (Presented with L. Maddock, S. Koenemann, J. Malvin), American Public Health Association, San Diego, CA
13. Preventing Latina teen pregnancy: The important role of parents. (Presented with L. Ralph, M.A. Biggs, S. Schwartz, A. Arons, A. Minnis, K. Marchi), American Public Health Association, San Diego, CA.
14. A Coalition of School Based Health Centers and Key Evaluation Findings. (Presented with S. Geierstanger, S. Soleimanpour, A. Faxio), American Public Health Association, San Diego, CA.
15. Burden of Asthma on Schools. (Presented with M. Kreger, D. Hughes, K. Sargent, S. Sabherwal, A. Robles, M. Standish), American Public Health Association, San Diego, CA.
16. Evaluating a Movement: Using Systems Change Outcomes. (Presented with M. Kreger, D. Hughes, S. Sabherwal, K. Sargent, A. Robles, M. Standish), American Public Health Association, San Diego, CA.
17. They'll Use it if it's Free: Contraceptive Choices Among Uninsured low-Income Women. (Presented with D. Rostovtseva, M.A. Biggs, S. Holtby, C. McCain, C. Lewis, H. Thiel de Bocanegra, D.G. Foster, American Public Health Association, Philadelphia, PA.
18. Understanding Teens and the "Digital Divide: Can We Reach Low-Income Youth Online with Health Information? (Poster session with N. Berglas, S. Schwartz, L. Ralph), American Public Health Association, Philadelphia, PA.
19. Improving Attendance and Achievement by Improving Air Quality. (Poster session with M. Kreger, S. Sabherwal, K. Sargent, J. Nielsen, A. Robles, M. Standish), American Public Health Association, Philadelphia, PA.
20. He Was so Happy, So I Was Happy Too: Male Partner Influences on Latina Teen Childbearing Decisions. (Presented with S. Schwartz, L Ralph, M.A. Biggs) American Public Health Association, Philadelphia, PA.
21. Youth Friendliness: How Do Family Planning Clinics Measure Up? (Presented with N. Berglas, M.A. Biggs, S. Navarro), American Public Health Association, Philadelphia, PA.
22. Translating Research to Impact Public Policy: California's Experience with Parental Involvement Legislation for Minor's Abortion in the 2005, 2006, and 2008 Elections. (Presented with L. Ralph), American Public Health Association, Philadelphia, PA
23. Evaluating Policy Advocacy: Employing Systems Change Outcomes. (Presented with M. Kreger, D. Hughes, S. Sabherwal, K. Sargent, A. Robles, M. Standish), American Public Health Association, Philadelphia, PA

24. Discussing Intrauterine Contraception at the Family Planning Visit: A Missed Opportunity for Client Education. (Presented with S. Schwartz, M.A. Biggs, S. Holtby, C. McCain, D. Rostovtseva), American Public Health Association, Philadelphia, PA.
25. Unplanned Pregnancies Among Young Adult Latinas: The Influence of Partners, Fertility Concerns, and Individual Aspirations. (Presented with L. Ralph, S. Schwartz, M.A. Biggs) American Public Health Association, Philadelphia, PA.
26. Approaches to Evaluating Advocacy and Policy Change: An International Comparison. (Presented with J. Kaye, A. Jackson, M. Billera, A. Gardner, L. Nascimento, S. Geierstanger), American Evaluation Association, Orlando, FL.
27. How Traditional Evaluation Thinking and Frameworks Can Be Adapted for Advocacy/Policy Evaluation. (Presented with J. Kaye, S. Ladd, D. Dunet, E. Chappelle, L. Gase, M. Kreger, S. Sabherwal, K. Sargent, A. Robles, M. Jhawar, M. Standish, American Evaluation Association, Orlando, FL.
28. Clinica Alta Vista: Providing an Integrated Model of Prenatal Care for Latina Adolescents and Their Families. (Poster presented with S. Soleimanpour, S. Ng, V. McCarter.) AFL Annual Conference, Oakland, CA.
29. Does Experience Matter? Quality of Reproductive Health Care Provided to Latino Adolescents (Poster co-authored with: LA Botkin, SA Fishkin, C.D. Brindis, E. Ozer, C. Kapphahn). Society for Adolescent Medicine Annual Meeting. Toronto, CANADA.
30. Traditional versus Centering: Which model of care leads to improved outcomes for Latina pregnant and parenting teens and their infants? (poster co-authored with S. Soleimanpour, S. Ng, V. McCarter) American Public Health Association Annual Meeting. Denver, CO.
31. Burden of Asthma on California Schools: Losses in Student Attendance, Achievement, and Revenue. (presented with M. Kreger, A. Arons, K. O'Brien, M. Standish) American Public Health Association Annual Meeting. Denver, CO.
32. Evaluating Policy Advocacy: Lessons from an Environmental Policy Initiative in California. (presented with M. Kreger, A. Arons, M. Standish) American Public Health Association Annual Meeting. Denver, CO.
33. It takes a community: CBOs and family planning providers collaborate to increase access to reproductive health services for low-income populations. (Poster co-authored with S. Schwartz, N. Berglas) American Public Health Association Annual Meeting. Denver, CO.
34. Can you get pregnant when you're on your period? Negotiating Sex Education: Questions & Misinformation"(presented with E. Villasenor, S. Kaller) American Public Health Association Annual Meeting. Denver, CO.
35. Pushing the Envelope beyond the pill and condoms: Teen Knowledge and attitudes towards long acting, reversible contraceptives. (poster co-authored with L. Maddock, D. Richardson, J. Funk). American Public Health Association Annual Meeting. Denver, CO.
36. Health of young people in the United States, 1991-2008: Trends in critical national health objectives. (Presented with N. Jiang, L. Kolbe, D. Chul Seo, N. Kay) American Public Health Association Annual Meeting. Denver, CO.
37. Assessing Health Policy Change Using an Online Survey Instrument. (Presented with A. Gardner, L. Nascimento, S. Geierstanger). American Evaluation Association Annual Meeting. San Antonio, TX.

38. Burden of Asthma on California Schools: Statewide and Local Attendance and Financial Losses and academic Achievement Analysis. Presented with M. Kreger, R. Guide, M. Bullen, M. Standish). American Public Health Association Annual Meeting. Washington, DC.
39. Advocating for Healthy Schools: Employing a Systems Change Framework to Assess Health and Education Policy Advocacy in California: Breaking Down Silos." (Presented with M. Kreger). American Public Health Association Annual Meeting. Washington, DC.
40. Client Demographics and Service Characteristics of California Title X and Non-Title X Family Planning Providers. (Presented with H. Thiel de Bocanegra, F. Maguire, M. Puffer, K J Horsley). American Public Health Association Annual Meeting. Washington, DC
41. School Based Behavioral Health Services in a Diverse, Urban Setting: Making a Difference. (Presented with S. Soleimanpour, S. Ng, V. McCarter, S. Geierstanger). American Public Health Association Annual Meeting. Washington, DC.
42. Meeting the Needs of Latino and African American Youth: School Based Behavioral Health Interventions. (Presented with S. Soleimanpour, S. Ng, V. McCarter, S. Geierstanger). American Public Health Association Annual Meeting. Washington, DC
43. Taking the Pulse: Potential for Assessing the Impact of Yoga and Mindfulness Programs on Youth. (Poster Presentation with L. Maddock, S. Geierstanger, E. Hendrick, S. Ng, N. Berdjis). American Public Health Association Annual Meeting. Washington, DC.
44. A Question of Hope ("Una Cuestion de Esperanza"). US Film Festival. (Presented with M. Antonia Biggs, K. Marchi, P. Braveman). American Public Health Association Annual Meeting. Washington, DC
45. Lessons Learned From State Departments of Insurance/> Implementation of the Age 26 Health Reform Provision." (Poster presented with Alexander Blum and Amanda Giordano). AcademyHealth Annual Research Meeting, Washington, DC.
46. One Product, Multiple Health Needs, Saving Lives: A Multidisciplinary Approach for the Prevention of Unintended Pregnancies and Sexually Transmitted Infections. (Poster presented with Bethany Young Holt) California Wellness Foundation Conference on Women's Health. Los Angeles, CA.
47. Improving Reproductive Environmental Health through EPA Policy. (Poster presented with Plumb M, Trowbridge J, Charlesworth A, Woodruff TJ). American Public Health Association Annual Meeting. San Francisco, CA
48. Intervening at a Critical Juncture: Women's Motivation to Use Intrauterine Contraception Immediately Following an Abortion. (Poster presented with Biggs MA, Levy S, Teig E, Arons A) American Public Health Association Annual Meeting. San Francisco, CA.
49. Building on Youth Assets to Improve Reproductive Health: Teen Pregnancy Prevention Programs in California. (Poster presented with Maddock L, McCarter V.) American Public Health Association Annual Meeting. San Francisco, CA
50. Uneven Progress: An Assessment of Sex Education policies and Practices in California Public Schools. (Poster presented with Combellick S.) American Public Health Association Annual Meeting. San Francisco, CA.
51. Teen Pregnancy Prevention Education in California: Adapting Curricula to Fit the Local Context. (Poster presented with Arons A Decker M, Malvin J) American Public Health Association Annual Meeting. San Francisco, CA.

52. Free Drinking Water Access and Barriers to Improving Water Access and Intake in California Schools." (Poster presented with Patel A, Hecht K, Hampton K, Grumbach J, Chandran K, Braff-Guajardo E.) American Public Health Association Annual Meeting. San Francisco, CA.
53. Writing on the Wall: The effects of Neighborhoods on Teen Reproductive Health. (Poster presented with Isquick S, and Decker M). American Public Health Association Annual Meeting. San Francisco, CA.
54. Making Do with Less: The Impact of State Budget Cuts on California's Teen Pregnancy Prevention Programs." (Invited Panel presentation, with Yarger J and Malvin J). American Public Health Association Annual Meeting. San Francisco, CA.
55. Expanding Universal Coverage: Reproductive Health Vouchers in Cambodia (Poster presented with Brody C, Freccero J, Bellows B).American Public Health Association Annual Meeting. San Francisco, CA.
56. Stayin' Alive and Thriving: Exploring Multiple Dimensions of SBHC Sustainability. (invited Panel presentation with Kaller S, Geierstanger S, and Brown S). American Public Health Association Annual Meeting. San Francisco, CA.
57. The Last Bottle Standing: Sports Drink and Bottled Water Access in California Public Schools. Patel A, Braff-Guajardo E, Hampton KE, Grummon A, Brindis CD. [3806.113]Annual Pediatric Academic Societies meeting, Institute of Medicine National Academies.
58. Understanding Contraceptive Use in the United States. American Public Health Association Annual Meeting; **Brindis, CD** Moderator.
59. A Qualitative Study of the Healthcare Access and Concerns of Latino Dreamers. With Raymond-Flesch M, Siemons R, Pourat N, Jacobs K, **Brindis CD**. Poster Presentation. 2014 Meeting of the Pediatric Academic Society. Vancouver, Canada. May 2014.
60. Adolescents and Young Adults Under Health Care Reform: Explanation of Benefits (EOBs) and Patient Confidentiality. Keynote Address, **Brindis CD**, AcademyHealth Child Health Services Interest Group, June 7, 2014.
61. Glass Half Full: A Comparison of Water Delivery Options to Improve Students' Water Intake in Schools. Patel A, Braff-Guajardo E, Hampton KE, Grummon A, **Brindis CD**. Poster presentation. 2014 Meeting of the Pediatric Academic Society. Vancouver, Canada. May 5, 2014.
62. Where Have All the Teens Gone? Decline in Adolescent Female Participation in California's Family Planning Program Following Cuts in Outreach Funding. Panel with Yarger J, Daniel S, Biggs MA, Malvin J, **Brindis CD**. American Public Health Association Annual Meeting, New Orleans, LA.
63. Operationalizing Resilience-Building and Life Course Planning with Pregnant and Parenting Adolescents in California. Panel with Kreger M, Tebb K, Truebridge S, **Brindis CD**. American Public Health Association Annual Meeting, New Orleans, LA.
64. Implementation of the Affordable Care Act (ACA): How Are MCH Populations Doing? Panel with Walker DK, Witgert K, **Brindis CD**, Comeau M, Peifer KL. American Public Health Association Annual Meeting, New Orleans, LA

65. Meeting the Social-Emotional Needs of Students: Creating Alternatives to the School-to-Prison-Pipeline. Panel with Kreger M, Sargent-Cairoli K, Thrasher J, Rucker P, Redmond, C, **Brindis CD**. American Public Health Association Annual Meeting, New Orleans, LA
66. School Health Center Evaluation with a "Twist" of Quality. Panel with Shelly Kaller S, Lutsky M, **Brindis CD**. American Public Health Association Annual Meeting, New Orleans, LA.
67. Sexually Transmitted Infection Services and Adoption of Effective Contraceptive Methods. Poster Presentation with Daniel S, Biggs A, Malvin J, **Brindis CD**, Yarger J. American Public Health Association Annual Meeting, New Orleans, LA.
68. California Family Planning Providers' Challenges to Same Day Long-Acting Reversible Contraception (LARC) Provision. Poster Presentation with Biggs MA, Malvin J, **Brindis CD**, Yarger J. American Public Health Association Annual Meeting, New Orleans, LA. 2014
69. Potential Role of Family Planning in an Era of Health Care Reform: Patient Perspectives on Primary Care Needs and Insurance Eligibility. Poster Presentation with Daniel S, Biggs A, Malvin J, **Brindis CD**, Yarger J. American Public Health Association Annual Meeting, New Orleans, LA. 2014
70. Characteristics of the Undocumented Young Adults Eligible for the Deferred Action for Childhood Arrivals. Poster Presentation with Pourat N, Lucia L, Hadler M, **Brindis CD**, Jacobs K, Siemons R, Talamantes E, Raymond-Flesch M. American Public Health Association Annual Meeting, New Orleans, LA. 2014
71. Meeting Them More Than Halfway: Adolescent Perspectives on Patient-Centered Care. Poster Presentation with Uy-Smith EL, Lofink HE, Padrez R, Trudnak Fowler TE, Koenig KT, Fairbrother G, **Brindis CD**. Society for Adolescent Health and Medicine Annual Meeting, Los Angeles, CA. 2015
72. Measuring Up to the Common Core: What is Known About the Delivery of Primary Care Services in the School-Based Health Centers (SBHC). Uy-Smith EL, Grumbach K, **Brindis CD**. Society for Adolescent Health and Medicine Annual Meeting, Los Angeles, CA. 2015
73. Moving Beyond Health Care Access: Evidence-Based Practices for Young Adults. Irwin CE Jr., Lau J, Ozer E, **Brindis CD**. Workshop Session. Society for Adolescent Health and Medicine Annual Meeting, Los Angeles, CA. 2015
74. Headstand Yoga & Mindfulness School Program. Geierstanger S, Ng S, Maddock L, **Brindis CD**, Gutmann-Gonzalez A. Poster Presentation: California School Health Association Conference, San Diego, CA. 2015
75. Fulfilling the Vision: The Role of Enrollment Workers in Promoting Health Insurance Access." Raymond-Flesch M, **Brindis CD**. American Public Health Association Annual Meeting, Chicago, IL. 2015
76. Risk and Resilience Factors Associated with Frequency of School-Based Health Center Use. Soleimanpour S, **Brindis CD**. American Public Health Association Annual Meeting, Chicago, IL. 2015
77. School-Based Health Centers and Adolescents' Access to Reproductive Health Care. Soleimanpour S, Geierstanger S, Kaller S, Ng S, McCarter V, **Brindis CD**. American Public Health Association Annual Meeting, Chicago, IL. 2015

78. Lessons from the ACA's Medicaid Expansion Front-Lines: Perspectives of Enrollment Workers. Raymond-Flesch M, **Brindis CD**. American Public Health Association Annual Meeting, Chicago, IL. 2015
79. Transforming Statewide Policy into Community-Wide Practice: School Disciplinary Policy and Health Disparities. Kreger M, Sargent-Cairoli K, **Brindis CD**. American Public Health Association Annual Meeting, Chicago, IL. 2015
80. Evaluating Consumer Engagement in Health Care: Strategies and Tactics as an Evaluation Framework. **Brindis CD**, Hughes D, Schmidt LA, Jacobs L. American Evaluation Association Annual Meeting. Chicago, IL. 2015
81. Video: A Multi-Purpose Evaluation Method? **Brindis CD**, Hughes D, Schmidt LA, Jacobs L. American Evaluation Association Annual Meeting. Chicago, IL. 2015
82. The Political Prioritization of Preterm Birth: A Policy Analysis Using a Prioritization Framework." Poster Presentation. Consortium of Universities for Global Health Annual Conference. San Francisco, CA. 2016
83. Young Adults and the Affordable Care Act. Irwin CEJr, **Brindis CD**, Ozer E, Park J, Hemlin E. Workshop: Society for Adolescent Health and Medicine Annual Meeting, Washington, DC. 2016
84. What, Me Worry? Youth Perceptions of Pregnancy and STIs. **Brindis CD**. Oral Presentation, Abstract. American Public Health Association Annual Meeting, Denver CO. 2016
85. Cultivating Clinical Connections: Opportunities and Barriers to Increasing Youth Access to Clinical Sexual Health Services in California. Decker M, Gutmann-Gonzalez, **Brindis CD**. Poster Presentation. Society for Adolescent Health and Medicine Annual Meeting, New Orleans, LA. 2017
86. Honoring Their Roots: Crating and Cultivating Positive Connections with Latino Adolescents and Young Adults. O'Brien SJ, Mondardez J, Garcia-Huidobro A, **Brindis CD**. Raymond-Flesch M. Workshop Presentation. Society for Adolescent Health and Medicine Annual Meeting, New Orleans, LA. 2017
87. Impacto Perinatal: El Embarazo de Adolescentes en Mexico y en California: Politicas Publicas y Consecuencias Programaticas. **Brindis CD**, Decker MJ, Gutmann-Gonzalez A. Instituto Nacional de Perinatologia, Mexico City, Mexcio. Reunion Anual INPer 2017: Salud Sexual y Reproductiva del Adolescente: April 4, 2017.
88. Barriers and Enablers to Care for Young Adults Churning Between Health Plans. Yarger J, Tilley L, **Brindis CD**. Oral presentation. American Public Health Association Annual Meeting, Atlanta, GA. 2017
89. Health Literacy Challenges for Young Adults Experiencing Churning Health Insurance Coverage. Tilley TL, Yarger J, **Brindis CD**. Oral presentation. American Public Health Association, Atlanta, GA. 2017
90. Use of an mHealth Application, Health-E You/ Salud iTu, to Improve Sexually Active Latina Adolescents' Contraceptive Knowledge, Self-Efficacy and Use. Tebb K, **Brindis CD**. Poster Presentation. Pediatric Academic Society (PAS) Meeting. Toronto, Canada. May 5-8, 2018.

91. An Opportunity for Intervention: Teen Dating Violence Among California's Adolescents in Out-of-Home Settings. Rutman S, Decker M, **Brindis CD**. Oral Presentation. American Public Health Association, San Diego, CA. November 10-14, 2018.

92. Improving Capacity to Implement an Evidence-Informed Case Management Intervention for Expectant and Parenting Adolescents: Results from a Statewide Training Evaluation. Tebb K, **Brindis CD**, Pressfield L, Campa M. Poster Presentation. American Public Health Association, San Diego, CA. November 11, 2018.

93. Increasing Interest and Uptake of LARCs among Latina Adolescents using a Mobile Health Application, Health-E You/Salud iTu. Tebb K, Pollack L, Wang L, Adams SA, Sang B, Ozer E, **Brindis CD**. Oral Presentation. Pediatric Academic Society (PAS) Meeting. Baltimore, MA. April 30, 2019.

94. The Promise of Adolescence. Level L, **Brindis CD**. Roundtable Discussion. Society of Preventions Research Annual Meeting. San Francisco, CA. May 30, 2019.

95. Migration Roles in the Lives of Latina Youth: A Binational Comparison. American Public Health Association, Philadelphia, PA. November 2-6, 2019.

96. Redesigning the Ivory Tower to Address Preterm Birth through Community-Academic Partnerships. American Public Health Association, San Francisco, CA. October 24-28, 2020.

97. The Nature and Impact of Trauma on 1.5 Generation Immigrant Youth During Parental Separation and Reunification. Journal of Adolescent Health. 2012 Feb 1; 50(2):s3-s4. Schapiro SN, Kools KS, Weiss WS, **Brindis BC**.

98. Use Of Youth-Centered Mobile Health Application, Health-E You/Salud iTu, To Reduce Disparities In Contraceptive Knowledge, Access And Unintended Pregnancy Among Sexually Active Latina Adolescents. Journal of Adolescent Health. 2019 Feb 1; 64(2):s40-s41. Tebb TK, Trieu TS, Rodriguez RF, Pollack PL, Adams AS, Ricco RR, Renteria RR, Hwang HL, Ozer OE, Sandoval SD, **Brindis CD**

99. Contraceptive Communication Among Adolescents Who Use Long Acting Reversible Contraception. Journal of Adolescent Health. 2020 Feb 1; 66(2):s115-s116. Tebb TK, Schwartz SE, Rodriquez RF, Reed RR, Tancredi TD, **Brindis CD**, Dehlendorf DC.

100. Adapting to Political Barriers in Conducting Teen Pregnancy Prevention Research: Use of Social Media as an Expedited Recruitment Strategy. Journal of Adolescent Health. 2020 Feb 1; 66(2):s115. Tebb TK, Schwarz SE, Rodriguez RF, Reed RR, Tancredi TD, Brindis CD, Dehlendorf DC.

101. Development and Pilot Feasibility Trial of a Co-Developed Teen Pregnancy Prevention Community Program in a Midwest Rural Latino Community. Journal of Adolescent Health. 2025 Mar 1; 76(3):s63-s64. Barral BR, Miller MM, Ramirez RM, Lopez LM, Brindis BC, Miller ME, Cramer CE, Ramaswamy RM.

102. Transcreating an Unintended Teen Pregnancy Prevention Program for Latino Teens Living in Rural Communities. Journal of Adolescent Health. 2024 Mar 1; 74(3):s59-s60. Barral BR, de Miranda dE, Ramirez RM, Miller MM, Miller ME, Ramaswamy RM, Brindis CD.

103. In the Face of Adversity: Pandemic Mental Health Protective Factors for Adolescents Who Have Experienced Adverse Childhood Experiences. Journal of Adolescent Health.

2024 Mar 1; 74(3):s57. Raney RJ, Weinstein WS, Ganson GK, Testa TA, Jackson JD, Pantell PM, Glidden GD, Brindis CD, Nagata NJ.

OTHER CREATIVE ACTIVITIES

1. Espinoza I, Anaya E, Ortiz R, Hernandez G, Bazeza B, Hinojosa S, **Brindis CD**, Laski L, Romero M. Manual de Capacitacion para Consejeria en Planificacion Familiar. Training manual for family planning counselors. Grupo Interinstitucional de Trabajo en Salud Reproductiva, Queretaro, Mexico and Center for Reproductive Health Policy Research, Institute for Health Policy Studies, University of California, San Francisco.
2. **Brindis CD**, Philliber S. Evaluating School Linked Services: Methods, Problems and Results. Philliber Research Associates, Accord, NY.
3. Card JJ, **Brindis CD**, Peterson J, Niego S. Evaluating Your Comprehensive Adolescent Pregnancy Pre-vention Program. (sponsored by the Centers for Disease Control and Prevention-http://www.socio.com/index.htm) Los Altos, CA: Sociometrics Corp.
4. Kent H, **Brindis CD**, Margolis R, Teipel K. Adolescent Health: A Community Perspective. Maternal and Child Health Continuing Education on DC-ROM. Rocky Mountain Public Health Education Consortium. University of Utah http://services.tacc.utah.edu/rmphec/http://services.tacc.utah.edu/rmphec/adolescent_health_outline.html
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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., *et al.*, *Plaintiffs*, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants*.	No. 1:25-cv-11913-IT

DECLARATION OF ANNE MARIE COSTELLO

I, Anne Marie Costello, declare as follows:

1. I am employed by the Department of Health and Human Services (HHS) in the Center for Medicaid and CHIP Services (CMCS) at the Centers for Medicare & Medicaid Services (CMS), located at 7500 Security Boulevard, Baltimore, MD 21244. I am a Deputy Director for CMCS. I have held this position since January 2020. Before that, I served as the Director of the Children and Adults Health Programs Group within CMCS. I have been employed at CMS since 2010. In my role as a Deputy Director of CMCS, I manage a team of professional and administrative staff with a variety of advanced degrees in fields including economics, law, medicine, public health, public policy, finance, and business operations. My team is responsible for policy development, management, oversight, budget, and performance issues related to Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP) on behalf of CMS. My team and I regularly interact with representatives from states and other stakeholders.

2. Medicaid is a joint state/federal partnership. States are responsible for providing care to Medicaid beneficiaries and do so through both fee-for-service (FFS) and managed care delivery systems. States design their Medicaid programs including determining which delivery system(s) to utilize for providing care to Medicaid beneficiaries and which benefits are offered in each delivery system. The federal government outlines Medicaid program requirements and reviews and approves many components of a state's Medicaid program, such as underlying authorities for benefits, eligibility, fee-for-service provider reimbursement rates, managed care, and managed care contracts and rates.

3. The federal government also contributes federal financial participation (FFP) towards the Medicaid program. Federal law and regulations require that CMS issue advanced funding (through initial grant awards) to states at the beginning of each quarter based on CMS-reviewed state expenditure estimates.

4. Once the advanced funding request is approved, the state can draw down the federal advance for the allotted amount as costs are incurred. 42 C.F.R. 430.30(d)(3). The State draws down federal funds through a subaccount operated through the Payment Management System (PMS) application within HHS' Program Support Center (PSC). Section 430.30(d)(3), 42 C.F.R., provides that the grant award authorizes the State to draw Federal funds as needed to pay the Federal share of disbursements. The state's quarterly federal Medicaid award is only to be used to reimburse Medicaid providers for actual payments. 42 C.F.R. 430.30 and 45 C.F.R. 95.13.

5. Those initial awards are reconciled to actual state expenditures following a finalization process that includes quarterly CMS reviews of state-submitted, actual expenditures and state draw-downs from its PMS subaccount. The Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64) is the accounting statement that

each state Medicaid agency submits each quarter to CMS to claim FFP for its Medicaid expenditures.

6. The Form CMS-64 is a summary of actual expenditures derived from source documents including invoices, payment vouchers, governmental funds transfers, expenditure certifications, cost reports and settlements, and eligibility records. It does not include claim-level information.

7. Medicaid provider payment occurs at the state level CMS does not directly pay providers. In the fee-for-service delivery system, the state Medicaid agency must conduct prepayment review for all claims received.[1] Additionally, in both the fee-for-service and managed care delivery systems, the state or the health plan respectively, must generally pay 90 percent of clean claims (i.e., claims that can be processed without obtaining additional information) within 30 days of the date of receipt.[2] Although CMS is not involved in the process, CMS therefore understands that a Medicaid provider in any given state can generally expect to receive payment from the state within 30 days of submitting a claim for service rendered to a Medicaid beneficiary.

8. Family planning services and supplies are a mandatory Medicaid benefit in accordance with Section 1905(a)(4)(C) of the Social Security Act. Family planning services must also be provided to individuals receiving Medicaid services through an Alternative Benefit Plan, as described in Section 1937(b)(7). This benefit can be provided in both the fee-for-service and managed care delivery systems.

[1] 42 CFR 447.45(f)
[2] 42 CFR 447.45(d)(2) 42 CFR 447.46(c). In a managed care delivery system, this requirement applies only to managed care organizations (MCOs), and the MCO and its providers may, by mutual agreement, establish an alternative payment schedule.

State E pe d ture Report a d C a s or FFP

9. To claim FFP, each state submits its aggregate expenditures on a quarterly basis to CMS electronically via the Medicaid Budget and Expenditure System (MBES) using the Form CMS-64. The state submits this form electronically to CMS 30 days after the end of each quarter (January 30, April 30, July 30, and October 30).

10. When submitting its quarterly expenditures, each state certifies that its expenditures are allowable under federal requirements. The Form CMS-64 consists of a series of forms that separate expenditures based on certain categories of services (typically aligned with statutorily defined benefit categories such as inpatient hospital services, nursing facility services, etc.). The Form CMS-64 is CMS's official accounting record of Medicaid expenditures.

11. CMS must assure that state expenditures claimed for federal matching funds under Medicaid are programmatically reasonable, allowable, and allocable in accordance with existing federal laws, regulations, and policy guidance. To achieve this, CMS relies primarily upon quarterly reviews of the Form CMS-64 performed by CMCS financial management staff across the country. The quarterly expenditure review process is complex, with up to 225 individual reporting lines for each state, which can result in over 1,000 pages of detailed expenditures each quarter. For each quarter, CMS Medicaid financial staff has 60 days to complete their review, including verifying the accuracy of reported expenditures determining whether the expenditures are properly supported verifying the authority for FFP in the expenditures and verifying the federal match rate.

12. CMS has a standard National CMS-64 Review Guide which is used by staff to ensure consistency of the reviews. The Review Guide targets specific areas on which to focus the review, based on risk, while also providing flexibility for staff and managers to use their

professional discretion to expand or curtail the review based on the complexity of the state's program and issues identified during the review process.

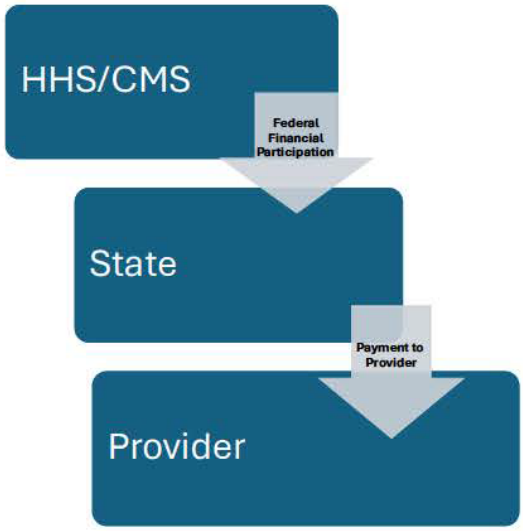
13. Although review times may vary, it typically takes CMS up to 6 months from the date of submission of Form CMS-64 to pay any additional FFP requested by the state.

14. Section 1132(a) of the Social Security Act requires states to claim FFP for Medicaid and CHIP expenditures within two years of the date of the expenditure. Implementing regulations at 45 C.F.R. 95 Subpart A specify FFP will be available only if the state files a claim within two years after the calendar quarter in which the expenditures were made. Under certain limited circumstances, the Medicaid statute and regulations provide for exceptions to the two-year time limit. Section 1132(a) of the Act and regulations at 45 C.F.R. 95.19 specify that time limit does not apply for any claims that: (a) are an adjustment to prior year costs (this is limited to interim payments reconciled to actual cost) (b) result from an audit exception (c) result from a court-ordered retroactive payment or (d) for which the Secretary determines there was good cause for the failure by the state to file the claim within the time period.

Med ca d Fee or Ser ce

15. In a fee-for-service delivery system, the state directly reimburses providers for each service delivered to Medicaid beneficiaries. States claim FFP for these costs from CMS.

16. The graphic below illustrates the payment relationship in a fee-for-service delivery system at a high level:



Medicaid Managed Care

17. Managed care is the predominant delivery system for most Medicaid beneficiaries. In a managed care delivery system, the state contracts with risk-based health plans[3] to provide services to Medicaid beneficiaries who are enrolled in the plan (known as enrollees). The state executes a contract with one or more health plans, and this contract outlines the contractual responsibilities of the plan. The state pays health plans capitation payments for taking on these contractual obligations.

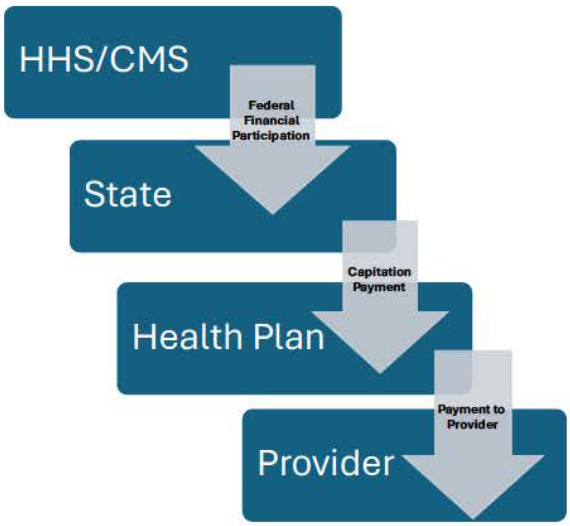
18. A capitation payment is a periodic payment (generally monthly), that a state makes to a health plan on behalf of each beneficiary enrolled under a contract, similar to a health insurance

[3] 42 CFR 2. There are three types of risk-based health plans (often referred to as managed care plans): (1) MCOs; (2) prepaid inpatient health plans (PIHPs); and prepaid ambulatory health plans (PAHPs). Generally, MCOs are comprehensive health plans while PIHPs and PAHPs are limited benefit plans.

premium paid in employer-sponsored insurance. The state makes this payment regardless of whether the particular beneficiary receives services during the period covered by the payment.

19. The health plan is responsible for contracting with a provider network, negotiating provider payment rates, and paying providers for covered services. Health plans are responsible for maintaining a sufficient provider network to meet the needs of the anticipated number of enrollees. In managed care, enrollees are generally restricted to only utilize the provider network of a health plan (i.e., network providers) with some exceptions for out-of-network providers. A network provider has a provider agreement with a health plan or subcontractor of that plan.[4] Network and out-of-network providers submit claims to the health plans for payment and health plans pay both network and out-of-network providers.

20. The graphic below illustrates the Medicaid managed care payment relationship at a high level:



[4] Definition of network provider in 42 CFR 438.2.

21. With respect to family planning specifically, Sections 1902(a)(23)(B) and 1915(b) of the Social Security Act allow Medicaid managed care enrollees to obtain family planning services and supplies from providers of their choice, including those out-of-network. Thus, in practice, when family planning services and supplies are included in managed care, enrollees receive family planning services from network providers and out-of-network providers, and both provider types are paid by the health plans.

* * *

I declare under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the foregoing is true and correct, to the best of my knowledge and belief.

Anne M. Costello -S
Digitally signed by Anne M. Costello -S
Date: 2025.07.14 15:29:03 -04'00'

Dated: July 14, 2025

ANNE MARIE COSTELLO

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., *et al.*, *Plaintiffs*, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants*.	No. 1:25-cv-11913-IT

DECLARATION OF DREW SNYDER

1. I, Drew Snyder, declare as follows: I am employed by the Department of Health and Human Services (HHS) as the Director of the Center for Medicaid and CHIP Services (CMCS) and Assistant Director of the Centers for Medicare & Medicaid Services (CMS), located at 7500 Security Boulevard, Baltimore, MD 21244. I have held this position since January 2025. In my role as CMCS Director, I oversee a team of professional and administrative staff with a variety of advanced degrees in fields including economics, law, medicine, public health, public policy, finance, and business operations. My team is responsible for policy development, management, oversight, budget, and performance issues related to Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP) on behalf of CMS. My team and I regularly interact with representatives from states and other stakeholders.

2. Medicaid is a joint state/federal partnership. States are responsible for providing care to Medicaid beneficiaries and do so through both fee-for-service (FFS) and managed care delivery systems. The federal government outlines Medicaid program requirements and reviews

and approves many components of a state's Medicaid program, such as underlying authorities for benefits and eligibility and managed care contracts and rates.

3. The federal government also contributes federal financial participation (FFP) towards the Medicaid program.

4. Congress recently amended the Medicaid statute as part of the One Bill Beautiful Bill Act, which President Trump signed into law on July 4, 2025. P.L. No. 119-21, 139 Stat. 72 (2025). Specifically, Section 71113 directs that no Medicaid funds "shall be used to make payments to a prohibited entity for items and services furnished during the 1-year period beginning on the date of the enactment of this Act[.]"

5. Section 71113 defines a prohibited entity as an entity (including its affiliates, subsidiaries, successors, and clinics) that, as of October 1, 2025, is an organization described in section 501(c)(3) of the Internal Revenue Code of 1986; is an essential community provider (described in section 156.235 of title 45, Code of Federal Regulations) that is primarily engaged in family planning services, reproductive health, and related medical care; provides for abortions other than those identified in the Hyde Amendment; and for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act for medical assistance furnished in fiscal year 2023 made directly, or by a covered organization, to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded $800,000.

6. CMCS staff have analyzed data in CMS's Transformed Medicaid Statistical Information System from 2023 and identified at least two non-Planned Parenthood entities, Family Planning Association of Maine, Inc., and Health Imperatives (which is based in Massachusetts),

that received more than $800,000 in Medicaid funding in fiscal year 2023, are 501(c)(3) essential community providers, and have provided for abortions other than those identified in the Hyde Amendment in the past.

I declare under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the foregoing is true and correct, to the best of my knowledge and belief.

Dated: 7/14/2025

/s/ Drew Snyder
DREW SNYDER

EXHIBIT 1

From: [redacted]
To: [redacted]
Subject: FW: [External]Notice of Temporary Restraining Order (TRO) in Planned Parenthood v. Kennedy
Date: Thursday, July 10, 2025 11:19:01 AM
Attachments: TRO.pdf

From: Costello, Anne Marie (CMS/CMCS) [redacted]@cms.hhs.gov>
Sent: Thursday, July 10, 2025 5:36 AM
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Cc: [redacted]@cms.hhs.gov>; [redacted]@cms.hhs.gov>
Subject: [External]Notice of Temporary Restraining Order (TRO) in Planned Parenthood v. Kennedy

Dear State Medicaid and CHIP Directors:

Please review the attached Temporary Restraining Order (TRO) in *Planned Parenthood Federation of America, Inc. v. Kennedy*. This TRO enjoins the Department and its "agents, employees, appointees, successors, and anyone acting in concert or participation with" the Department from "enforcing, retroactively enforcing, or otherwise applying the provisions of Section 71113 of 'An Act to provide for reconciliation pursuant to title II of H. Con. Res 14,' against Planned Parenthood Federation of America and its members; Planned Parenthood League of Massachusetts; and Planned Parenthood Association of Utah." It also requires the Department and its "agents, employees, appointees, successors, and anyone acting in concert or participation with" the Department to "take all steps necessary to ensure that Medicaid funding continues to be disbursed in the customary manner and timeframes to" the above entities.

If you have questions, please reach out to me at [redacted]@cms.hhs.gov.

Thank you
Anne Marie

Anne Marie Costello
Deputy Director
Center for Medicaid & CHIP Services
Cell: [redacted]

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., et al., Plaintiffs, v. ROBERT F. KENNEDY, JR., et al., Defendants.	)	Civil Action No. 1:25-cv-11913-IT

BEFORE THE HONORABLE INDIRA TALWANI, DISTRICT JUDGE

MOTION HEARING

Friday, July 18, 2025
9:01 a.m.

John J. Moakley United States Courthouse
Courtroom No. 9
One Courthouse Way
Boston, Massachusetts

Robert W. Paschal, RMR, CRR
Official Court Reporter
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P R O C E E D I N G S

(In open court at 9:01 a.m.)

THE DEPUTY CLERK: United States District Court is now in session, the Honorable Judge Indira Talwani presiding.

This is Case Number 25-cv-11913, Planned Parenthood Federation of America, Inc., et al., v. Kennedy, et al.

Will counsel please identify themselves for the record.

MR. SCHOENFELD: Good morning, Your Honor. Alan Schoenfeld for the plaintiffs, and I'm joined by a number of colleagues.

THE COURT: Good morning.

MR. SCHOENFELD: Thank you.

MS. HALL: Good morning, Your Honor. My name is Emily Hall for defendants, and I'm joined by Betsy Hedges.

THE COURT: Good morning.

So we are here on Planned Parenthood, et al.'s, motion for a preliminary injunction. And before we get into argument on the motion, I wanted to start with a sense of the parties as to the framework for the overall case. This isn't a scheduling conference, but I'm curious whether you view this as a case that ultimately will require discovery or disputed facts that would go to trial, summary judgment, motion to dismiss.

What are the parties anticipating here?

MR. SCHOENFELD: Thanks, Your Honor. Do you want me here?

THE COURT: Wherever you're comfortable, but since I go back and forth between people, you're probably better off there.

MR. SCHOENFELD: Okay. So for plaintiffs, I think it depends on what happens today. But I think that --

THE COURT: Well, all that can happen today is a preliminary injunction can be granted or denied.

MR. SCHOENFELD: Understood. But subject to Your Honor's views about the particular claims that might have merit, I think this is a case where limited discovery and summary judgment are likely to resolve the case on the merits for a permanent injunction. So I think that's our view.

THE COURT: Okay. Limited discovery and summary judgment?

MR. SCHOENFELD: I think that's probably where we think this is going.

THE COURT: Okay. I'm not holding anyone to it. I'm just trying to have a sense of it.

MR. SCHOENFELD: Understood.

THE COURT: Counsel?

MS. HALL: Thank you, Your Honor.

I think I generally agree with plaintiffs'

position. I think the necessity of a trial would probably depend on what comes out in discovery and whether facts remain contested at that point, but we would expect that some limited discovery at least will be necessary before summary judgment.

THE COURT: Okay. Thank you.

MS. HALL: Thank you.

THE COURT: So my usual practice here is to start with the moving party. I go back and forth as I work my way through arguments, and that's how I intend to proceed.

So with that --

MR. SCHOENFELD: Yeah.

THE COURT: -- you may start.

MR. SCHOENFELD: Thanks very much, Your Honor.

As Your Honor noted, this is an application for a preliminary injunction from Congress's attempt to defund Planned Parenthood by excluding it from the Medicaid program.

The statute prohibits certain entities from obtaining Medicaid reimbursement.

THE COURT: I'm going to interrupt you. There are three plaintiffs here: Planned Parenthood Federation of America, Inc., which I believe is here on its own behalf and on behalf of its members, and then two other plaintiffs, Planned Parenthood of Massachusetts and Planned Parenthood of Utah. I may not have their exact names correctly, but those

are the three parties in front of me.

And it does seem to me that, on both sides, many of the arguments may depend on what we're talking about. The statute itself doesn't use the word "Planned Parenthood." The defendants' brief uses "Planned Parenthood" as a single term for all of the plaintiffs throughout.

It would be helpful here to the extent that you can, that you use the word -- you use words to distinguish what you're talking about.

MR. SCHOENFELD: Certainly.

THE COURT: If you are intending to talk about Planned Parenthood and its members, perhaps use "plaintiffs." If you're talking about Planned Parenthood Federation, maybe it would be helpful to call it "federation," and if you're talking about the members, maybe "members," just so I can understand the arguments that you're making.

MR. SCHOENFELD: Yeah, absolutely. And that's a helpful direction.

Our view, of course, is that what Congress has attempted to do here is exclude Planned Parenthood, the federation, and its members from the Medicaid program. And I think that that framing guides our discussion of the first three constitutional claims, which are brought on behalf of all of the plaintiffs. And so those are the bill of attainder, equal protection, and First Amendment retaliation

claims brought on behalf of everyone.

There's the back end of the complaint claims, which are the claims for the nonqualifying members, including Planned Parenthood of Utah, which I'll address separately.

But to frame the statute, Congress's intent here was to exclude Planned Parenthood and all of its members from the Medicaid program. The statute prohibits certain defined entities from obtaining Medicaid reimbursement, making it impossible for those entities to provide healthcare to Medicare patients, those most in need of high-quality care and those least likely to find care elsewhere.

The statute defines the term, quote, "prohibited entity" to include a narrow universe of healthcare providers that meet four gerrymandered, conjunctive statutory criteria, making it certain that Planned Parenthood, and virtually only Planned Parenthood -- and I'll get to that point about the "virtually only" later in connection with the bill of attainder argument -- are defunded.

THE COURT: I'm going to give you time here, so you don't need to rush.

MR. SCHOENFELD: Yeah, I just wanted to -- I understand that that's a point of contention, so I just wanted to make sure that I'm not taking it as common ground.

THE COURT: And I just want to make sure the reporter can keep up.

MR. SCHOENFELD: Yes. I apologize. I'll slow down. This is the peril of being from New York.

The starting premise of the government's defense of the defunding statute is that Congress may choose not to subsidize abortion. That is entirely beside the point. That is not --

THE COURT: Let me just stop you here. No disagreement here as I'm proceeding here that Congress may defund abortion?

MR. SCHOENFELD: For purposes of this argument, that's not an argument that we're making. I think there are limits to that, but that is not --

THE COURT: Okay.

MR. SCHOENFELD: -- at all material to these arguments because that's not what the statute does.

What the statute does do is to punish Planned Parenthood and its members for their expressive of association. They're coming together for support and advocacy for abortion rights.

Now, how do we know that? We know that because the statute doesn't just regulate conduct. It doesn't simply exclude abortion providers. It also excludes nonabortion providing affiliates of those entities.

And that point is important not just for the nonqualifying members, but for the entire statute, for all of

the claims --

THE COURT: Okay. So let me stop you there. Just, again, for definitional purposes, the plaintiff has put -- plaintiffs have put evidence in the record as to their corporate structure, that each -- and each member is a separate -- that each member is a separate legal entity with its own board of directors and so forth.

And am I correct on my reading of the record that the defendants do not challenge those corporate formation -- the evidence as to corporate formation?

MS. HALL: Your Honor, I think we do not contest that they are separately registered 501(c)(3) organizations, but the characterization of those relationships we do contest.

THE COURT: Okay. So let me just pull this apart a little bit.

When I consider parties in front of me and the rights and responsibilities of parties in front of me, I have persons, actual people, and I have legal entities. And sometimes the legal entities' boundaries can be disregarded, their alter ego theories, their disregard of corporate structure theories, et cetera.

And sometimes people work together. You've got conspiracy analysis. You have, sometimes, liability for people who are unincorporated associations, all of those

things.

But just so -- again, I want to be very precise here. Right now, the record in front of me, which could come out differently in discovery, but the record in front of me is that I have 48 distinct legal entities, 47 separately -- separate legal entities, which are the members, and then Planned Parenthood Federation, which is a separate legal entity.

Any disagreement about that as to the record?

MS. HALL: As to the parties to this case, I -- as I understand Planned Parenthood Federation's theory of standing, they are proceeding on behalf of their 47 members.

THE COURT: And on their own behalf, I think.

MS. HALL: Exactly, and on their own behalf. So that theory of standing would bring in the 47 members. But I just want to be clear that the -- all 47 have not sued in their own name.

THE COURT: Fair distinction. I appreciate that, and I didn't mean to suggest otherwise. I'm simply trying to understand the legal relationships here.

And I think what you said is you would disagree about -- I think the words you used were the characterization of those relationships, but I want to be clear in what way you're disagreeing about the characterization of those.

You're not disagreeing that as -- that these are

separate legal entities?

MS. HALL: I'm not disagreeing that they are separately incorporated.

THE COURT: Well, what's the difference between the way I phrased it?

MS. HALL: I think "separate legal entities" could potentially have several different meanings.

THE COURT: Okay. Tell me what the different meanings are of "legal entities."

MS. HALL: So, for example, under certain statutes like this one, the word "entity" is defined to include affiliates. So it says an entity including its affiliates.

THE COURT: Okay. But that doesn't make it a legal entity.

I'm stepping back. I'm not saying you can't have multiple legal entities come together for reasons. That's why we have conspiracy statutes, and we have alter ego piercing, and you could have a statute that says we're going to treat all these people together. I'm just saying they're separate people legally that you're treating together, and I'm just wondering if you have any disagreement with that.

MS. HALL: I'm hesitant to use the word "entity" because that's the language in the statute. I --

THE COURT: Okay. If I use the word "legal entity," which I am using to reference what I understand, you

know -- if you sue somebody, for example, the summons goes to a legal entity, which is the LLC, the corporation, whatever, the different form of a legal entity.

And we have rules. For example, practicing here, a legal entity has to have an attorney represent them. They can't just come in on their own.

So in that concept that they're -- not to say that legal entities can't be combined for purposes of things, any disagreement that, on the evidentiary record before me, there are 48 different legal entities?

MS. HALL: On that specific understanding and that granular level of understanding of what "entity" means in this particular context --

THE COURT: And, again, legal entity. I'm not trying to substitute that for prohibited entity, just a legal entity. We have these different legal entities.

MS. HALL: Accepting your definition of that term, yes, I agree.

THE COURT: Okay.

MS. HALL: Thank you.

THE COURT: Okay. Please proceed.

MR. SCHOENFELD: And just to finish up on that point, Your Honor, the evidence before the Court at the preliminary injunction stage is that these are 48 separately incorporated independent, individual healthcare providers, 47

affiliates that provide healthcare in the Planned Parenthood Federation of America.

THE COURT: That does not provide healthcare.

MR. SCHOENFELD: That does not provide healthcare, correct. So it is a membership organization of the 47 independent healthcare-providing organizations.

THE COURT: Okay.

MR. SCHOENFELD: The thrust of the government's argument is that it is -- that Congress is permitted to regulate on the basis of abortion. That's not the issue before the Court today.

The issue before the Court today is the fact that this statute, in fact, goes farther; and it regulates the relationship between and among Planned Parenthood members and the federation and in that way singles out the federation and its members for particularly negative treatment, punishment under the bill of attainder clause; and it burdens their First Amendment expressive association rights.

As Your Honor recognized in the amended TRO, *Jaycees* is the signal case here. It is precisely the coming together of these entities for those purposes that is the defining feature of the statute. It is repeated twice in the definitional provision of "prohibited entity," and therein lies the constitutional problem.

If Congress had simply regulated abortion, maybe

some of the government's arguments would have force, but that is not what the statute does. It is doing something more. And that is the substance of all of the constitutional claims, which I'll get into in a moment.

Think of it this way: If of the many hundreds of health centers operated by the 47 independent affiliates, only one provided abortions, every single affiliate would be excluded from the Medicaid program, as would the federation. That structure is manifestly not about regulating abortion. It's not about using abortion as the determinant of eligibility for participation in a nonabortion Medicaid program.

It is the association, the *Jaycees* protected association work, that is the subject of the government's action here.

And -- am I interrupting you?

THE COURT: No, you're not, but I do like to go back and forth.

MR. SCHOENFELD: Yes, please.

THE COURT: I know you want to get through all your arguments, but I actually think I would like to hear from the defendants.

MR. SCHOENFELD: Do you want me to sit?

THE COURT: Yeah, why don't you sit.

I'd like to hear from you on this point. Is the --

are the plaintiffs correct that if, as of October 1st, one -- let's use Planned Parenthood Massachusetts, that as of October 1st, Planned Parenthood of Massachusetts continues to provide abortions, and every other Planned Parenthood member has stopped providing abortions, are they all defunded for the year nonetheless?

MS. HALL: Your Honor, I don't know the answer to that question because the agency has not yet had an opportunity to engage with the structure of Planned Parenthood. These are precisely the sorts of factual disputes that we raised in our brief.

THE COURT: Okay.

MS. HALL: I don't know all the details of Planned Parenthood's corporation structure, the level of control that's exercised; and those factual questions are what would determine the answer to your question.

THE COURT: Okay. So as I understand what I'm supposed to do here, at least on the first few counts, they're facial challenges. And if there's a plausible construction of the statute that's not unconstitutional, then the statute can't be attacked on a facial challenge, correct?

MS. HALL: If there's a -- if there is a plausible application of the statute that does not violate the Constitution, yes.

THE COURT: Okay. So what's the plausible

application here?

MS. HALL: Your Honor, I think that an application -- certainly, the plaintiffs don't contest that Planned Parenthood League of Massachusetts, one of the named plaintiffs, will, as of October 1st, satisfy all of the conditions of the statute.

THE COURT: No, no. I'm not asking -- I think the question is what -- well, let me not interrupt you. Today, what is the plausible -- what is the plausible construction of the statute that is constitutional?

So if Planned Parenthood of Massachusetts is providing abortions on October 1st, is there a plausible construction of the statute that would allow depriving other members of Medicaid funds if they are not providing abortions?

So, in other words, assuming that the scenario I'm suggesting happens, that -- and it may not be all 46 that stop providing, but we know at least three don't provide abortions, and we know that the others could change providing abortions or not. Presumably, that's one of the things that Congress wanted to do, is stop abortions. So between now and October 1st, some of these other entities might stop providing abortions.

Is there a construction of the statute that would be constitutional as -- in that -- if that's the scenario?

MS. HALL: Yes, Your Honor. And I think two points here. One, on your precise question regarding a construction of the statute, association and affiliation are different concepts.

THE COURT: Okay.

MS. HALL: Affiliation is a concept in corporate law regarding the relationships between particular legal entities, to use Your Honor's definition of that term; and it's common in the law in regulations, in contracts, in statutes, to impose conditions, impose restrictions, impose obligations on an entity and its affiliates.

And not all of --

THE COURT: Okay. So let me just -- let me just stop you for a minute here. Your permissible construction is that I do use corporate law principles and treat this as an affiliation under corporate law? Is that -- is that how you're wanting me to proceed?

MS. HALL: Your Honor, at this stage, for the existence of a facial challenge, any permissible application of the statute --

THE COURT: And I'm just trying to understand what the permissible application is that you're urging me.

MS. HALL: Right. And so I think there are several permissible applications; and so this is my first, but if you don't -- if you may, I'd like to talk about a few.

THE COURT: Sure.

MS. HALL: So, first, yes, a construction of the statute that applies the corporate law understanding of affiliate -- and, specifically, the concept of common control and two entities that are under common control are considered affiliates -- I think that would be a permissible application of the statute. It would not intrude on association rights because affiliation and association are different concepts, and not every -- association can exist without legal corporate affiliation.

Secondly --

THE COURT: Let me just -- I'm just trying to slow down here and understand your arguments here. So one construction is that if the statute is prohibiting payment of funds under the control of the entity providing abortions, then it's legal?

MS. HALL: Not quite, Your Honor. Our -- I think the common control doesn't require that -- to use the kind of triggering entity example as Planned Parenthood of Massachusetts, since no one contests that that entity plans to perform abortions as of October 1st and that it received more than $800,000 in fiscal year 2023, Planned Parenthood League of Massachusetts does not need to itself control every affiliate that would fall within the statute, but it can be under common control with other entities.

THE COURT: So your contention is that the statute passes facial challenges under the First Amendment if one affiliate provides abortion and the other affiliates don't if they are both under control of a third organization, not under -- not that the one is under control of the other?

MS. HALL: That's true as well as if one is under the control of the other. Either would be sufficient to qualify as an affiliate under established principles of corporate law.

THE COURT: And in the event that the affiliates are not under the control as those words are understood in corporate law, would it be unconstitutional then?

MS. HALL: Your Honor, I don't think it would necessarily be unconstitutional then. I think if we were to set forward a different definition of "affiliate," probably some of those definitions, I think that's --

THE COURT: Okay.

MS. HALL: -- very plausible.

THE COURT: So what's the other definitions of "affiliates" that you would say would make this pass constitutional muster?

MS. HALL: Your Honor, I think that potentially, certainly, a narrower construction of "affiliate" that required, perhaps, an even closer corporate relationship. That could also pass constitutional muster.

I don't know what CMS and HHS will determine as to the scope of the facts that would be sufficient to establish affiliate status.

THE COURT: But for a facial challenge, don't -- they -- it's a hard standard for them on a facial challenge; but don't you have to give me a facially plausible interpretation, to which I then, on the preliminary injunction standard, say, well, their standard applies and, you know, we move away for today? They might have a challenge later as applied, but you have a facially plausible explanation for what's going on here.

MS. HALL: Your Honor, that leads into the second point that I was going to raise, which is that as I understand the facial challenge case law, it focuses on whether there is any constitutional application of the statute. And, certainly, if the complaint is association, that can -- there is no associational reason that Planned Parenthood League of Massachusetts, for example, could fall within the statute if it continues to perform abortions as of October 1st.

And so that certainly, on their theory, which is that it's unconstitutional because it restricts their associational rights, Planned Parenthood of Massachusetts is not being brought within the scope of the statute because of any association. And so that is a permissible application of

the statute, and that alone should defeat a facial challenge because a facial --

THE COURT: Okay. But I also have plaintiff Planned Parenthood of Utah. Planned Parenthood of Utah doesn't fall within this unless it's an affiliate.

MS. HALL: That's right, Your Honor, and so I think that presents Planned Parenthood of Utah with the opportunity to mount an as-applied challenge. But the question of a facial challenge is whether it can be permissibly applied at all. And the statute can certainly be permissibly applied even on their association theory to entities that independently qualify.

And so there's no facial challenge that can be based -- that could be premised on this association theory because they do not contest, the plaintiffs do not contest, that some Planned Parenthood members as of October 1st, according to their plans, will fall within the scope of this statute themselves without reference to any affiliates.

THE COURT: Okay. Back to you. Your response.

MR. SCHOENFELD: Thanks very much, Your Honor.

So I think the -- first off, there is no plausible application of the statute that satisfies the Constitution. I think that standard -- and, of course, in this preliminary junction posture, we just need to show likelihood of success in demonstrating that there's no constitutional application,

which we have done --

THE COURT: I think you have to show substantial likelihood of success.

MR. SCHOENFELD: Even so, we do. I think the question of how that *Salerno* standard applies to something like the bill of attainder is less clear. If it's a bill of attainder, it's a bill of attainder; and it's a bill of attainder as to Planned Parenthood Federation and all of its members, and I'm happy to explain why.

But there is no constitutional application here for the simple reason that, as the government concedes in its brief, in order to escape the prohibition, a member need not only stop providing abortions, but it must, in the government's word, disaffiliate from every other affiliate. It is required to repudiate its association with --

THE COURT: Let's imagine for a moment that the only case in front of me was brought by Planned Parenthood Massachusetts. All right? Explain what you just said now as to Planned Parenthood of Massachusetts' rights.

MR. SCHOENFELD: Planned Parenthood of Massachusetts, like the other Planned Parenthood members, cannot be attained by a statute that is meant to particular target it for punishment, and that's irrespective of whether the prohibition on affiliation apply -- or the prohibition on providing abortion applies to it or some of its affiliates.

It is punished by this statute for its expressive association. That addresses bill of attainder.

For equal protection, they -- all of the Planned Parenthood affiliates are situated differently from all other abortion providers, not on account of their providing abortion, but on account of their association with Planned Parenthood. So the provision of abortion is not the determinative of the equal protection claim; it is the something more that is the --

THE COURT: Well, if another healthcare provider -- and I think the examples that the defendants give come from Maine. But if you have a healthcare provider that is not a member of Planned Parenthood, but is -- receives more than $800,000 as a nonprofit, as a community healthcare provider, they're also covered.

So why doesn't that undercut your argument?

MR. SCHOENFELD: So every case that has addressed this question in both the bill of attainder and equal protection context has essentially said that if there's collateral damage from Congress's overinclusive definition that doesn't undermine the specification requirement of the bill of attainder, nor does it undermine an equal protection challenge, everyone --

THE COURT: So on the equal protection challenge, you point out that the -- if the game here was to stop

abortions, they would have targeted entities that received Medicaid funds that also perform abortions without the other three restrictions of it being a nonprofit, of it being community -- I guess the other two restrictions, being a nonprofit and being a community health provider.

So they responded to that to say that there's -- it's just a rational basis standard and that it's rational to only target nonprofits rather than for-profit abortion providers and that it is rational to only provide -- target those facilities that provide community family health services rather than other -- other entities.

What's your response to that?

MR. SCHOENFELD: So two arguments, Your Honor. The first is that we're not in rational basis review. We're in heightened scrutiny because this burdens Planned Parenthood and its members associational rights. They make no effort to argue that the statute satisfies any type of heightened scrutiny.

Second, they try to justify each of the separate conjunctive criteria separately. They never make an effort to justify the conjunction of those four statutory criteria. And they concede, they acknowledge, as do many members of Congress, that the purpose of this was to single out and defund Planned Parenthood.

The DC Circuit's decision in *Foretich*, which is a

bill of attainder case, I think is a really good example of this. The Court goes through, I think, eight different statutory criteria and essentially says, yeah, like, one of these standing alone might have a rational basis, but when you look at all of them together, the inexorable conclusion is that it was meant to single out the plaintiff for attainment.

And that's precisely what's happening here. I don't think the Court is required to sort of blind itself to the reality of what Congress was attempting to and has, but for the Court's TRO, successfully done, which is to defund Planned Parenthood.

The fact that there are two other providers among the many hundreds of abortion providers in the United States that are simply collateral damage to Congress's work here I don't think undermines any of the arguments we're making before the Court.

THE COURT: So you do make a factual assertion in your reply, and maybe it was also earlier -- I'm not sure -- but I didn't see a cite for it, and I'm wondering if it is in the record.

You say that -- first, you say none of the requirements are tied to the number of abortions provided, and that's just by a facial reading of it. It doesn't say how many abortions provided. It just says that you fit into

these different categories.

And then it says the vast majority of abortion providers based on the -- accounting for the majority of abortions provided are not covered by this statute.

Do I have that somewhere in the record? Is that in the expert declaration or not?

MR. SCHOENFELD: I need to look, and I'll get you the cite if it's there. It looks like -- I want to look at it with my own eyeballs, but let me go back and look at it.

So the -- sorry. Can you just ask your question one more time?

THE COURT: Well, so you're making the assertion that the vast majority of abortion providers accounting for the majority of abortions provided in this country are not covered by the statute. And I'm wondering if that's in the record.

MR. SCHOENFELD: So the Custer declaration does say that 60 percent of abortions in the United States are provided by non-Planned Parenthood member providers. We also know -- I don't --

THE COURT: That 60 percent of abortions or -- 60 percent of abortions -- maybe it doesn't matter -- except I think it does.

The relevant universe we're comparing are entities that get Medicaid funds, because if there are things

happening in entities that don't get Medicaid funds at all, that's not something that the government is working with.

So here the government's made a decision that Medicaid funds can't go to entities that receive over $800,000 in Medicaid funds for nonabortion-related matters that are nonprofits and that are community healthcare providers.

And you're saying to me that there's a bigger different group that they're not defunding, but is that a different group that also receives Medicaid, or is that just a different group?

MR. SCHOENFELD: I don't think it's in the record what percentage of abortions either Planned Parenthood or non-Planned Parenthood providers who receive Medicaid for nonabortion services provide.

I also don't think it matters, because ultimately, if this -- if this statute's criteria related only to the provision of abortion, and we've separated out the affiliate provision -- right? -- it's the affiliate provision that, I think, makes this rotten to the core. If it was just about abortion -- and even if you had some size metrics like the amount of revenue or the amount of Medicaid revenue, maybe we would be dealing with an arguably constitutional statute.

But that's not what we have here. The statute does not just disqualify entities that meet those criteria, but it

sweeps in affiliates; and the purpose for which it sweeps in those affiliates is to penalize Planned Parenthood, to single out Planned Parenthood and penalize it, not merely for the provision of abortion, but because of the advocacy for which it's known.

THE COURT: Well, so the government offers some different responses there. They're saying they're singling out nonprofits because nonprofits have the benefit in the tax code of being nonprofits. And so they shouldn't be singling -- they shouldn't be -- there's no reason to stop Medicaid funds going to for-profit company entities that provide abortion.

Any response to that?

MR. SCHOENFELD: That may arguably be a rational basis standing alone for a statute that has that as the determining criterion. It is hard to imagine a rational basis for those four separate criteria streamed together; and in any event, we're not in rational basis. It burdens the association of Planned Parenthood Federation and its members, and we know that because of the use twice in the statute of this affiliate language.

And because it burdens the associational rights of the federation and its members, this is subject to heightened scrutiny. They don't argue that that satisfies heightened scrutiny. They don't argue that that's a rationale that

would persuade a court, that Congress is entitled to burden associational exercise.

I think it's critical to the analysis here that, as the government concedes, stopping abortion is not enough under the statute. An entity, in order to be covered, in order to exclude itself from this prohibition, must disaffiliate from the Planned Parenthood Federation and from all other members. In --

THE COURT: And there's no disagreement about that, right? An entity can't get out from this prohibition if -- an entity that -- an entity can't get out from this prohibition by stopping abortions if it remains affiliated with Planned Parenthood Federation or other Planned Parenthood members?

MS. HALL: If it is legally affiliated within the meaning of the statute, yes.

THE COURT: Okay.

MS. HALL: So that -- that depends on -- and that's -- again, affiliation is different from association.

MR. SCHOENFELD: And, Your Honor, may I on this point?

THE COURT: Yeah.

MR. SCHOENFELD: So I agree that association and affiliation are different. I don't actually understand the government to dispute that Planned Parenthood Federation and

its members are an association for First Amendment purposes.

I think they take the view that Congress can regulate abortion, and that's what it's doing. But we say it's doing something different. I don't understand them to dispute the premise that it is an association.

MS. HALL: Your Honor, I -- no, the government does not dispute that it is an association; but it is also -- again, we don't have the facts to know exactly the nature of the Planned Parenthood network. And that's something that we, of course, submit in our brief, that we need those facts in order to determine whether they, in fact, have the requisite affiliate relationships, and that's why this -- the last three claims are premature.

MR. SCHOENFELD: Well --

MS. HALL: But --

MR. SCHOENFELD: I apologize.

THE COURT: Hold on one minute, both of you.

Maybe we can make this argument slightly more complicated, which is -- it uses the term "affiliates" in two places, but then it also uses the word of "part of a nationwide healthcare provider network."

What does that mean?

MS. HALL: Your Honor, again, the agencies have not had an opportunity to analyze the statute, issue guidance. But I will note that in other -- and I don't have the cite,

and I apologize for that. In another, I believe, regulatory provision, but it may be a statutory provision, a "nationwide healthcare provider network" is used to refer to a system of providers that are operating, I believe, typically, under a certain type of health insurance program.

So, again, I --

THE COURT: Like Medicaid?

MS. HALL: No, I don't think so, Your Honor. I -- I think it's something more akin to a managed care system. But, again, I -- I don't have definitive interpretation as to that language. But I --

THE COURT: But with regard to definitive interpretations right now, a healthcare provider right now can accept or not accept Medicaid patients right now for yesterday or tomorrow.

And is it the government's position that they have to sort of make their best guess and risk either turning away patients or serving patients but not getting paid for it while they hear, in the first instance, what the government contends this means?

MS. HALL: Your Honor, I think that the potentially covered entities have a few options. They can choose not to serve patients that -- for which they might not get reimbursement, and that's already true as to certain services. It may be unclear in certain circumstances whether

services will ultimately be covered by Medicaid, and a provider has to make a call ahead of time before submitting a claim for reimbursement as to whether they expect that it will be reimbursed or not. There's inherently some level of risk in that.

THE COURT: Except this is 55 percent of their customer base, but yes. Okay. So they have to -- so one option is they make a decision that they go ahead with it even if they might not get paid. Okay.

MS. HALL: That's right.

They might also choose to forgo providing services in the interim and then wait out the litigation and wait until their claims are resolved and then, at that point, decide to either resume or to cease depending on the outcome of the litigation.

That's -- that's a typical course. That's a typical situation in litigation. You have -- plaintiffs are not -- plaintiffs cannot typically get a preliminary injunction just to have enhanced legal certainty. That is not -- you know, uncertainty as to application of a law is not itself grounds for a preliminary injunction.

THE COURT: What's your response -- and I think this came in the reply brief, so you haven't had a chance on the papers. But the plaintiffs assert that if they submit claims for services provided and then they're later deemed to

not -- to be a prohibited entity, that they could be prosecuted under the False Claims Act.

MS. HALL: Well, Your Honor, the False Claims Act has a scienter requirement and a materiality requirement. And so if the claims that are submitted include appropriate disclaimers, I suppose, of their reason that they think they're entitled to reimbursement because they don't think that the law applies to them, then I think that would be substantial evidence against scienter, a substantial evidence against materiality that would preclude that sort of liability, which only attaches when there's a state of mind.

THE COURT: And what if they simply said, "It applies to us on its face, but we think it's unconstitutional," and they write that on their Medicaid claims?

MS. HALL: Your Honor, I certainly am not a false claims expert, and this came in yesterday. But I believe that that sort of assertion could be grounds for denial of reimbursement, but I don't think that if the entities submitted that and said, you know, by -- "On its face, this statute applies to us, but we're still seeking reimbursement because we think that the statute is unconstitutional," I would be very surprised if the requisite scienter was found there.

THE COURT: And just in terms of the timing, if

we're having limited discovery here, presumably this case is not going to be resolved in the next three months, so if plaintiffs submit claims for Medicaid services -- let's make this very simple.

If Planned Parenthood Massachusetts submits claims for Medicaid services and marks those claims as submitted because this statute is unconstitutional, when would those claims have to be filed, and when would those claims normally be paid?

MS. HALL: As I understand it, the statute requires providers to submit their reimbursements within two years of providing services, and there's even an exception for later -- later filings when it's pursuant to a court order. So they have a long time to submit those reimbursements.

As I understand it, the states typically are responsible for processing claims within 30 to 90 days. And then at that point, those claims are submitted to the federal government, which for I think the next three months of claims probably would not actually reach any kind of determination by the federal government until around April of 2026.

THE COURT: Okay. So I understand your on-the-ground argument that you don't agree with the -- or the feasibility of the choice that plaintiff -- defendants' counsel is suggesting. But as to how Medicaid reimbursement functions, do you disagree?

MR. SCHOENFELD: I think, in general, what the government has described is correct. But if I may --

THE COURT: Sure.

MR. SCHOENFELD: -- I think, number one, the two scenarios that counsel for the government has described are catastrophic, right? Stopping to provide services for Medicaid patients during this period while the legal ambiguity, as they view it, is worked out is catastrophic for the providers and for their patients.

And the idea that a categorical exclusion of a provider is similar to figuring out whether one particular blood test is covered by Medicaid or not --

THE COURT REPORTER: I'm sorry; if you can say that again slower.

MR. SCHOENFELD: Let me try to remember it.

There is a significant difference between not knowing whether you as a provider are excluded from the Medicaid program and whether you can see any patients at all versus not knowing whether one particular blood test is provided.

If government counsel would like to make a binding representation in court that there will be no False Claims Act or other liability either under federal law or state law as a result of Planned Parenthood members submitting these claims during the period where the constitutionality of the

statute is being worked out and can guarantee that there will be immunity for that conduct, both at the state level and the federal level, we might be in a different place.

I still think that there is irreparable harm from the disruption in the provision of services. I don't understand the government to be making that offer.

And just to go back to, I think, the first point that government's counsel made, the notion that this is ambiguous and the Court needs to wait for CMS or HHS to effectuate, the very clear congressional directive to defund Planned Parenthood in its entirety I think is not to be credited by this Court.

We are at a preliminary injunction stage. We have demonstrated a likelihood of success on the merits. We've also demonstrated right now eminent, manifest, critical, existential harm. And the idea that the government might eventually take a different view, all while this irreversible harm is being done at the provider level, I think does not justify the Court staying its hand.

THE COURT: What if a court, this Court, were to take the view that if "affiliates" means "association" at the end of the day and the corporate structure is disregarded, that that would be unconstitutional; and, therefore, in the interest of constitutional -- avoiding finding the statute unconstitutional, I read the statute to say that only

abortion-providing entities and not nonabortion-providing entities -- namely, Planned Parenthood Federation itself and the affiliate members -- could be included in that, where does that get us?

MR. SCHOENFELD: I think what Your Honor is contemplating is something like severing the offending clause from the statute. That's not a remedy the government has asked for. And I think, you know, the constitutional avoidance issues are limited here. But I think you're asking, essentially, to rewrite -- not you -- a Court, hypothetical --

THE COURT: Well, I'm asking you, if I were to do that, and I think it's a fair response to say you're rewriting the statute if that's what you're saying.

MR. SCHOENFELD: Yeah.

THE COURT: But that's my questions to you.

MR. SCHOENFELD: So the government hasn't asked for severance of that, and I would imagine it's because the severance standard is whether a court is confident that Congress would have enacted the statute without the severed provision. And that is not -- the government can't meet that standard here.

I think the upshot is the Court is required to take Congress at its word, and the evidence is in front of the Court in terms of the way the provision is written.

Because this is a case about impermissible targeting, the Court is welcome to consider the views of members of Congress describing precisely why this was enacted. All of the government's case law, *O'Brien* and *Hubbard*, all of those cases make a specific proviso for bill of attainder cases and attainder-like cases where there's evidence in the record that a particular entity was targeted, and they carve out these sorts of cases from considering those views.

But even if the Court didn't consider their views, I don't think there's any illusion about what Congress was trying to do here. And so while that might kind of practically solve some of the problem with the constitutional issues, it's simply not a remedy that I think is available to the Court.

MS. HALL: May I be heard, Your Honor?

THE COURT: Absolutely.

MS. HALL: What plaintiffs' counsel is now describing as a remedy that is unavailable is precisely what Count 4 of their complaint asks for. Count 4 of their complaint asks for a declaration that the proper interpretation of the statute simply as a matter of statutory interpretation --

THE COURT: And you think that count is not ripe, not properly before me, there's no constitutional grounds,

et cetera. So, presumably, that count, even if they've argued for it, you would agree they don't get that?

MS. HALL: Your Honor, I would agree that they don't get that at a preliminary injunction posture because it would be inappropriate to issue a declaratory judgment in a preliminary injunction posture because it's not ripe, because there's no cause of action.

THE COURT: Just to be clear, a preliminary injunction, you're absolutely right. I can't give a preliminary declaratory judgment, but they've never asked for that. They've asked for, at the end of the day, a declaratory judgment; and then they've asked for a preliminary relief because of those concerns. So there is no preliminary declaratory judgment on the table.

MS. HALL: As I understood their request, they were also asking for a preliminary declaration.

THE COURT: Yeah, I went back and looked at the thing, and I don't see it there.

MR. SCHOENFELD: Your Honor, may I respond on the relationship --

THE COURT: Yeah.

MR. SCHOENFELD: -- between -- so Count 4 and Counts 1 through 3 are entirely independent of each other.

THE COURT: You know what? Count 4 -- counsel is right. I'm giving her a hard time about asking for a

preliminary declaratory judgment, but counsel is right that Count 4 by itself does nothing one way or another. But we have --

MR. SCHOENFELD: Sure.

THE COURT: -- the other counts and so forth. And I do think my point to you about Count 4 was simply to say you're telling me not to reach it. You're probably right that there's no reason to reach it in and of itself.

But what I do need to reach, I think, are the constitutional claims in 1 through 3 and 5 and 6.

MR. SCHOENFELD: Correct.

THE COURT: And in order to understand those claims, don't I have to understand what either -- what the statute says on its face or what you're urging me that the statute says, one or the other or both? But I don't get to just ignore what the statute says.

MS. HALL: That's right, Your Honor. And I think, to respond to your point, to your original point to opposing counsel about the sort of remedy that you are suggesting, I do think that this, the remedy that would be appropriate if Your Honor finds a likelihood of success on either Count 5 or Count 6, the associational and vagueness arguments and unconstitutional conditions arguments, the proper remedy would be to enjoin the statute's application as to the non- -- the allegedly nonqualifying members, as Your Honor

just suggested would be the proper remedy.

THE COURT: Well, what about the claim that Massachusetts Planned Parenthood and Planned Parenthood Federation are making that it is a First Amendment -- and maybe it's not Planned Parenthood Massachusetts, but maybe it is Planned Parenthood Federation, is making the argument that by penalizing anybody who associates with each other, you're essentially doing the -- it's because of the bill of attainder, it's because of the re- -- First Amendment retaliation, essentially, that these are First Amendment claims I need to worry about or protected constitutional claims I need to worry about?

MS. HALL: Well, Your Honor, I think if Your Honor finds likelihood of success on the bill of attainder argument, and I'm happy to talk about why that claim fails, but if Your Honor were to find likelihood of success on the bill of attainder argument, yes, I do think that would apply equally to all of the federation members as well as Massachusetts and Utah.

The same goes for the First Amendment retaliation argument.

As for equal protection, plaintiffs seem to suggest that the inclusion of affiliates renders it facially unconstitutional; but because there are 37 members or 36 members that the federation asserts would be covered by the

law in any event, that precludes a facial challenge on the basis of association because the -- those entities, even if there were no association issue with the statute, which, as we've asserted, there are certainly at least constitution -- at the very least, ways to read the statute that don't apply to the members, the other ten members, you can't -- the plaintiffs can't have a facial challenge based on association when 36 of their members would fall within the statute regardless of any association.

THE COURT: Well, Utah can have it.

MS. HALL: Your Honor, Utah -- according to plaintiffs' theory, Utah is a nonqualifying member. And so Utah has a standalone as-applied association claim and can argue on behalf of itself and, I think, sort of presenting the sorts of arguments that the other allegedly nonqualifying members would make that it cannot be constitutionally applied to them because it's targeting them based on alleged association.

Now --

THE COURT: How about Federation? Do they have an applied challenge? Because, essentially, what this is saying is that, in order to keep your funding, you have to -- the entities have to disassociate with Federation, and that's kind of what they're saying what the statute says.

MS. HALL: Your Honor, again, this is all dependent

on the facts and what the nature of these relationships are. But assuming that that bears -- ends up being true, then I think the federation could only seek that sort of relief as to members whose association rights would be impeded. I --

THE COURT: Why isn't it its own? So Federation has 48 members as they're sitting there. And in between now and October 1st, the members are thinking to themselves, "Can we continue providing healthcare services to our communities? If we didn't get an injunction here, we're faced with this dilemma. We either have to give up providing services to our communities. Only 4 percent of" -- whatever -- "some small percentage of our services are abortion anyway. We'll just give up those, abortion, and try to prevent the pregnancies from happening in the first place so we can decrease the number of abortions by providing contraception and so forth. And we're making these decisions; we're thinking it's more important for women to have access to contraception than it is to have an abortion, and we're making that decision. So, therefore, we're going to stop providing abortions." And maybe they'll make that decision over the next three months.

But doesn't the statute also say on its face that they need to disaffiliate with everybody else? And if so, isn't that meaning that, essentially, Planned Parenthood Federation's 48 members are going to fall away? Because some of these are going to think it's more important to either

prevent abortions by providing contraception or just to provide contraception.

They may think that providing women's health is critical, and so they're going to give up the 4 percent of their work doing abortions so that they can do the rest of their mission, but they now have to also give up being members of Planned Parenthood, right?

MS. HALL: Your Honor --

THE COURT: Planned Parenthood Federation. Sorry.

MS. HALL: Your Honor, if I follow the question correctly, I think one aspect that I would just note is that, in a footnote of plaintiffs' opening brief, they assert that, as of October 1st, their members will continue to provide abortions. So I'm not sure that there is a real --

THE COURT: But that's because they're asking me for a preliminary injunction. And if I say no to them for the preliminary injunction and they're actually faced with this issue on the ground of, "Do we stop providing healthcare in large communities" -- I mean, we know that three of their members have stopped providing abortions because the states they're in prohibited them from doing it.

So we know that, at some point, there's a real issue on the ground that people faced with that choice, even if they think it's unconstitutional, may think their mission of providing healthcare to poor people matters more and to

provide family planning and contraception other than abortion matters more, and maybe they're just interested in lessening the number of abortions -- who knows? -- but maybe they take a different position.

You would agree that, under the circumstance, unless they disaffiliate with Planned Parenthood, they run the risk that, having dropped their abortion service, they still won't get their family planning paid for. And that's chilling speech.

So they drop out. So, I mean, isn't that either penalizing Planned Parenthood Federation or interfering with Planned Parenthood Federation's First Amendment rights or their First Amendment rights of association?

MS. HALL: No, Your Honor, because I don't think that any of that is blocking these different organizations from engaging in speech collectively. Nothing in the statute precludes them from coordinating for advocacy purposes. Nothing in the statute precludes them from engaging in any First Amendment activity.

THE COURT: Except you're telling me that you don't know if coordinating for speech purposes might be the same as affiliation under the statute because you don't know what affiliation under the statute means.

MS. HALL: Your Honor, I don't think that coordinating merely for speech purposes without corporate

control is sufficient to fall within affiliation in the statute.

THE COURT: Okay. So we have now gotten a sentence here, because this really is kind of the critical thing.

In the government's view, as you're representing it, if there isn't corporate control, then banding together and supporting a -- the federation as a membership organization for advocacy would not limit people from participating in Medicaid, if they don't -- if they separately don't provide abortions?

MS. HALL: Simply -- that's correct, Your Honor, if it were simply for advocacy purposes.

To use maybe an easier example, if, for example, Planned Parenthood Gulf Coast, which I understand does not provide abortions, engaged in protected speech activity together with Maine Family Planning --

THE COURT: So as you sit -- stand here right now, is Planned Parenthood Gulf Coast covered by this or not?

MS. HALL: Your Honor, I don't know.

THE COURT: But you're telling me -- you're telling me that if they don't engage in speech and they're -- so are you saying that if -- I guess I'm just -- I'm not understanding it. How -- how is it that Planned Parenthood Gulf Coast, which doesn't provide abortions, has to sit here today and decide whether or not to provide Medicaid services

this next few months? I don't understand.

MS. HALL: Because it depends on the nature of the corporate relationship, which I don't have.

THE COURT: Okay. Tell me what it is that they need to worry about doing or not doing or what their relationship is or isn't. Is it their relationship as of October 1st or their relationship last fiscal year?

MS. HALL: Their relationship as of October 1st determines whether they are an entity, including its affiliates.

THE COURT: Okay. So what is it that they have to be careful of between now and October 1st to be able to continue to provide healthcare services in those states?

MS. HALL: Your Honor, I'm not in a position to set forth the precise contours of what sort of business relationships --

THE COURT: Give me imprecise ones. Give me anything.

MS. HALL: So, for example, Your Honor, I think that if an entity, if Planned Parenthood Gulf Coast, to use that example, has a contract or another formal agreement with Planned Parenthood Federation or with another member that requires it to take certain actions, that requires it to provide particular services, that requires it to abide by certain rules.

THE COURT: So if Planned Parenthood Federation says to Planned Parenthood Gulf Coast, "You may not turn away patients based on their gender," that would be enough?

MS. HALL: Your Honor, again, that alone, I don't know whether that would be enough.

THE COURT: What if Planned Parenthood Federation says, "You need to make available cancer screenings"?

MS. HALL: Your Honor, if -- if one entity is controlling what types of services another entity offers, then I do think that is a very relevant indicator of control.

THE COURT: So if Planned Parenthood has a -- I'm thinking sort of for franchises right now, right? So McDonald's says, if you have to have the McDonald logo, you need to have napkins out front and forks and knives. And if you don't have those kinds of things, you don't meet our standards for being a McDonald's franchise.

Is that sufficient type of control if that's what's happening here, if it's not related to abortion, if it's simply providing healthcare?

MS. HALL: If the only -- if the only requirement were you must have forks and napkins, again, I'm not sure that that would be sufficient alone to demonstrate control.

THE COURT: Well, but let's -- I mean, Planned Parenthood is -- they are associated in the sense of the way a trademark is associated, right? Planned Parenthood

Federation says, "A Planned Parenthood clinic, wherever it is across the country, can only use our Planned Parenthood logo if they provide certain minimum healthcare standards," right?

MS. HALL: That is my understanding. I don't believe that -- I'm not sure how -- what level of detail that is in the record. But that is my understanding, yes.

THE COURT: Okay. And you're saying that that, saying to these communities that they provide this level of healthcare that's mandated by Planned Parenthood Federation, would disqualify them from Medicaid funds?

MS. HALL: Your Honor, again, combined with other factors and other considerations, I think that here we have a question because I don't have the bylaws for these organizations. I don't have --

THE COURT: Right, but --

MS. HALL: -- this information --

THE COURT: Congress could have helped everyone out here and said the statute goes into effect, you know, after October 1st. And then everyone knows we've got to figure this all out between now and October 1st. But Congress didn't do that. Congress said this went into effect on the night of July 4th. And so between July 4th and September 30th, Gulf Coast and other entities have to figure out what they're doing.

MS. HALL: And, Your Honor, I think one indicator

for Gulf Coast is that in all of Planned Parenthood's outward facing materials, it appears to be described as a Planned Parenthood affiliate. And so I think that is a good indication that it may be covered by the statute.

THE COURT: Okay. And the reason it's covered by the statute is not because it provides abortion, because we know it doesn't provide abortion, but because it's a Planned Parenthood affiliate, which sort of goes into their argument that what you're targeting is Planned Parenthood, not abortions.

MS. HALL: No, Your Honor, I don't think that that's -- that that provides evidence of that. I think it's very common for Congress to include within the scope of a statutory restriction affiliates of an entity that engages in a primary behavior.

So, for example, there's a statute that governs -- excuse me while I find the citation.

THE COURT: Do you -- is there any disagreement here that Planned Parenthood Federation has a First Amendment right to advocate for abortion?

MS. HALL: No, I don't contest that there is a First Amendment right to advocate for abortion.

THE COURT: And are you saying that, because these entities are associated with each other because they say they're a Planned Parenthood affiliate, even though they

don't provide abortion, they can't get Medicaid funding, and it's for a reason different than that Medicaid -- that Planned Parenthood advocates for abortion?

MS. HALL: Your Honor, yes. This law has nothing to do with advocacy for abortion. It has to do with the provision of abortion. And, again, it is common for Congress to act on an entity that engages in a particular behavior along with entities that are affiliated with that entity.

And so the example that I was looking for was a law that requires organizations that are subject to foreign control to -- that engage in political activity to register with the attorney general. That's 18 USC Section 2386.

And under that law, "subject to foreign control" is defined to include an organization that is affiliated directly or indirectly with a foreign government. This is just another example of a statute.

And I don't -- I don't think that anyone would assert -- and perhaps I'm wrong about that -- that that statute which requires entities that are subject to foreign control, including affiliated, directly or indirectly, with a foreign government to register with the attorney general if they engage in political activity domestically.

THE COURT: Do foreign governments have a First Amendment right in this country?

MS. HALL: Your Honor, certainly not to the same

extent that an American citizen would.

MR. SCHOENFELD: Your Honor, if I might, I mean, the rational basis for that statute jumps off the page. If the concern is about government infiltration and the affairs of the United States, ensuring that a foreign company and its affiliates need to be subject to the same prohibition -- because, you know, who knows what the corporate organizational laws of Myanmar are, and if they're subject to some prohibition, certainly all their affiliates are.

But just to take a step back here, because I want to make sure that the claims remain clearly distinguished, there's a lot of talk about the Claims 4, 5, and 6; but to bring this back to the equal protection claim, the prohibition is on discrimination. The fact that the -- that Congress has chosen to discriminate against Planned Parenthood because of its advocacy isn't cured by the happenstance that one or more affiliates may otherwise be excluded from the prohibition.

It is no less a facial challenge. If a statute is adopted with discriminatory intent, the fact that someone might fall outside -- might otherwise be included in the prohibition doesn't do anything to disturb the equal protection showing.

If Congress said members of the Boston Bar Association may not serve as federal judges, and some person

was a member of the Boston bar -- and they said it because they don't like the position that the Boston Bar Association has taken on a particular issue, and some member of the Boston Bar Association was born outside the United States -- well, no, a federal judge can be born outside the United States -- had committed an --

THE COURT: A federal judge can be born outside of the United States, unlike the president.

MR. SCHOENFELD: Understood. And I caught myself and corrected myself -- had committed an infamous crime but was still a member of the Boston Bar Association, it is no less discriminatory -- I'm trying here with my hypothetical. It may not work.

But my point is if there is a member who is otherwise ineligible to be a member of -- a member of the federal judiciary, it doesn't lessen the discrimination against the Boston Bar Association or its members that Congress has chosen to single out the bar association for all of its expressive activity.

That's not how equal protection doctrine works. If it is purposefully discriminatory against an organization, Congress doesn't get the benefit of someone else, you know, one member or two members or however -- members, you know, being otherwise subject to some neutral provision or some, you know, subset of the gerrymandered criteria.

So this is a facial challenge because, in our view, it is inarguable that Congress has chosen to single out Planned Parenthood for this statutory prohibition on the basis not simply of its providing abortions, but also because of its association.

Congress is not permitted to require organizations, to put organizations to the choice of repudiating their First Amendment-protected association in order to receive government funds regardless of whatever other criteria apply to them.

THE COURT: Let me just dig in a little bit on that last point about their First Amendment rights. I think the government cites *Rust* a lot. And you responded in your reply that *Rust* supports you, not them.

MR. SCHOENFELD: Yeah.

THE COURT: Can you both discuss that a little bit? I mean, as I read *Rust*, Congress said you can't use Title X funds, essentially, for abortion-related counseling. And so it was a First Amendment challenge to that. And the Supreme Court said, yes, you can limit it that way.

But there's a pretty extensive discussion that it's okay -- the regulations, they basically -- they basically go through and say that the grantee -- they govern the project, that there's a project within what the entity's getting it. It limits what the project can do.

And the regulations govern the scope of the project's activity, leaves the grantee unfettered in its other activities. The grantee can continue to engage in abortion advocacy. It's simply required to conduct these activities through programs that are separate and independent from the project that receives the funds.

That's *Rust*, from '91. Is that not good law anymore?

MS. HALL: Your Honor, I think that that -- *Rust* is good law, and we rely on it, obviously, in our brief as well. But I think that the assertion that -- the suggestion that this case does not permit First Amendment advocacy is just wrong. This statute does not restrict Planned Parenthood or Planned Parenthood Federation or any of its members from engaging in advocacy.

THE COURT: I'm actually -- I'm actually sort of focusing in a little bit more, and maybe I -- I don't know the case law here at all. So, please, correct me.

What *Rust* seemed to be saying was you could limit the use of the funds the way you want it to be used; but you can't say if you're taking these funds over here, that same entity can't be doing other things over here.

So Planned Parenthood Massachusetts is saying, "We are doing -- over here, we're doing -- performing abortions; and we -- here, somewhere else, we are using money to pay

dues to" -- I don't know if they pay dues to Planned Parenthood Federation or whatever. They use it for their own advocacy.

"And then over here, we are performing Medicaid reimbursed services; and for that, we're seeking reimbursement."

Why isn't *Rust* read to say for whatever you're seeking Medicaid reimbursement, you cannot use those funds for anything; i.e., you cannot use the Medicaid funds for abortion; and, frankly, you can't use the Medicaid funds for abortion advocacy.

But you have 50 percent of other funds that are coming into your clinic. Doesn't *Rust* say you can use those other funds for not only advocacy, but abortion?

MS. HALL: Well, Your Honor, I think that there's a major difference between the situation in *Rust* and now, which is that, at the time, the Supreme Court considered performing abortions to be protected conduct. And that is not true in the wake of *Dobbs*. There is no right to perform abortions. There's no right to receive an abortion under the Constitution of the United States of America, and that makes a substantial difference because the conduct that is prohibited is performing abortions.

There's no --

THE COURT: But you're not getting Medicaid money

for performing abortions. But I think what you're saying is *Rust* is no longer good law to the extent that what it's -- you're saying, I think, that *Dobbs* overrules *Rust* in so far as *Rust* said, as long as you're not using the federal funds for abortion or abortion advocacy, you can do other things here.

And I think what you're saying to me now is that in the post-*Dobbs* world, we can withhold Medicaid funds from an organization that performs abortion, period, even if the funds aren't used -- even if it's not Medicaid funds.

So you're saying that what's happening here could -- Congress could have done this more broadly, that Congress could simply say no Medicaid funds goes to any healthcare provider that performs abortions.

MS. HALL: Yes, Your Honor. I don't think that there's a requirement that entities that receive federal funding be permitted to engage in activity that is not protected and that Congress wishes to discourage.

I think that, for example, if an entity had, you know, two sides of its business and one was providing Medicaid services and the other was engaging in fraud, Congress could say we don't want any federal funds going to an entity, even if the fraud is totally separate, that is engaged in fraud.

Likewise --

THE COURT: What if the conduct isn't illegal, though?

MS. HALL: Your Honor, I think the same is true. It doesn't have to be illegal, because Congress is not saying you're not allowed to provide abortions. It's simply saying, if you wish to provide abortions, we don't want to pay you for anything. We don't want to have a reimbursement relationship. We don't want to fund an entity that engages in conduct of which we disapprove.

THE COURT: In that same scenario, if the entity didn't engage in abortions but simply engaged in abortion advocacy, that, they couldn't limit the funds?

MS. HALL: Your Honor, I think that's a very different case, and I think we have --

THE COURT: But I'm asking you for the answer to that question.

MS. HALL: Judge Sotomayor's decision in the Mexico City case suggests that federal funds can be conditioned even on advocacy of a position that the government does not take. And this is -- again, it underscores why this case is not like a typical punitive case. It is not making it unlawful for Planned Parenthood entities to perform abortions.

It is simply saying if you want --

THE COURT: No, but I think what you're saying, to

be very clear, is I think what you're saying is it's okay to make it unlawful to advocate for abortions, no?

MS. HALL: No, Your Honor. That's not what I'm saying. It -- the -- Congress can say we don't want to give money to an entity that advocates for abortions.

THE COURT: Exactly. So that what you're talking about here isn't -- because this isn't designed -- this statute doesn't say we're not going to give Medicaid money to entities that perform abortions. I think if that had been the legislation, I think you might have had some other entities being concerned about what that would mean. I don't know that the -- I don't know where that goes.

But what you're saying is it is okay for Congress to stop entities who advocate -- from receiving funds if they advocate for abortion. I think that's what you're saying.

MS. HALL: Your Honor, that's not what this statute does, and so there's no need to opine on the --

THE COURT: But it does by the affiliation pieces.

MS. HALL: No, Your Honor. Again, it does not restrict the Planned Parenthood members from engaging in advocacy together or separately. It simply prohibits them from legally affiliating.

And, again, I think the affiliation point is maybe underscored by the financial relationship between the entities, which, again, I don't have a lot of visibility

into. But as I understand, all members pay some sum into Planned Parenthood Federation, and Planned Parenthood Federation also pays sums out to the entities.

So there is some kind of financial relationship between the entities that, again, is different from a simple association relationship. If the entities were only engaging together by, you know, putting out ad campaigns together that said, you know, "We want to change policies of this state or that state or we want to lobby Congress to change the law," that's a very, very different case. And that's not what we have here, based on the limited record.

Now, again, there could be a more developed record that demonstrates that, in fact, there are not these financial relationships; that, in fact, there are not these control relationships. These contracts that preclude the entities from ceasing to perform abortions where it's legal potentially, again, this is -- I'm trying to draw on the materials that I have, which are very limited.

But, again, I think that this is not something that is targeting speech advocacy. This is not something that's targeting that form of association. It's targeting corporate affiliation, which is a very different concept. And not every case that --

THE COURT: I am confused here. Are you really saying -- so you're saying this statute is limited to

corporate -- corporate affiliation and not association? That's sort of where we're landing on this?

MS. HALL: Mere First Amendment association would not be sufficient to render -- render an organization an affiliate under the statute.

THE COURT: But anything that is more than speaking, more than getting together on an ad campaign, such as if you want to put a Planned Parenthood sign outside, you have to meet certain standard of care, that would put everyone together?

MS. HALL: Your Honor, again, I think that one small condition for the use of a name or an endorsement is very different from the limited evidence that we have here. And so, again, I think we would need to know more about the nature of what exactly is required, what exactly is prohibited, what sorts of control are actually being exercised because that's -- I mean, Planned Parenthood, the plaintiffs, rather, in their opening brief, they set forth this definition of "affiliate" that they advance, they ask this Court to adopt, that has an understanding of control.

And they assert that they simply don't meet that control standard. But here, what I'm asserting and what the government asserts here is that there is a substantial factual dispute as to the level of control. And it is -- the application of the statute to any entity that does not itself

perform abortions is contingent on the interpretation and application to the facts, not any kind of question of just whether they have engaged in advocacy or speech together.

THE COURT: I come back to you. Do you understand *Dobbs* to have overruled the portion of *Rust* that --

MR. SCHOENFELD: No.

THE COURT: -- said if an entity performs this over here and what about the Sotomayor opinion, lower court Sotomayor opinion?

MR. SCHOENFELD: So I think that Judge Sotomayor's opinion, I think, is from 2002; and so I think you need to kind of refract it from *AOSI*, which is not an abortion case, which reaffirms the principle from *Rust* that what you do on your own time and dime is not subject to government regulation even if you otherwise accept government funding.

So the notion that the government is entitled to regulate at the grantee level, regardless of the program that they're expecting to fund, I think the Supreme Court rejected that in *AOSI*, which we discuss in our brief.

I also think that these kind of fine-grained questions about precisely what "affiliate" means and the degree of control do nothing to detract from the fact that what Congress was attempting to do here -- whether they did it successfully or not, I think, is immaterial.

What they were attempting to do here was to

penalize Planned Parenthood Federation and its members from engaging in their First Amendment protected associational rights and to deter them from doing that.

And the fact that they're required to repudiate that relationship, whatever it means, in order to qualify for these benefits, even if they don't provide abortions, is all the evidence the Court needs to find that it's a bill of attainder, find that it violates equal production under any standard of review, and find that it's retaliation in violation of the First Amendment.

THE COURT: Okay. Let me -- we're going to be running out of time soon here. Let me change gears for a minute and talk a little bit about irreparable harm.

It seems to me that there have been discussions in the papers, and I suppose my temporary restraining order covers one of these, but there's -- as I understand the plaintiffs' argument, you suggested that there was harm to First Amendment rights and then there's harm to the members' relationships, et cetera, with their patients and the closing of the facilities.

And then there was reference to the loss of care for patients. And you probably didn't make the argument, but I did include that loss of care for patients under irreparable harm. The government points out, I think, that that can properly be considered under the public interest,

but not under irreparable harm.

So -- any disagreement with you on that, that the harm to the patients is not in front of me today?

MR. SCHOENFELD: I disagree.

THE COURT: Okay.

MR. SCHOENFELD: So we do rely on the, you know, *Elrod* standard that even a minimal --

THE COURT: So let me just get that one off the -- or keep it --

MR. SCHOENFELD: Yeah.

THE COURT: We don't need to spend too much time discussing it. On the First Amendment violation, irreparable harm is -- the issue is whether there's a substantial showing of a First Amendment right violation. That's where the energy goes. If there is, then we have irreparable harm by definition under *Elrod*.

Any disagreement on that?

MS. HALL: Your Honor, I would just emphasize that, again, nothing in this law restricts advocacy.

THE COURT: But my point is that's a merits argument. And I may agree with you at the end of the day that they haven't made a substantial showing.

But if I disagree and I accept their premise that there is a substantial showing, and the next test done in a preliminary injunction is irreparable harm, harm to

First Amendment rights is irreparable harm by definition under *Elrod*, right?

MS. HALL: *Elrod* does hold that harm to First Amendment rights is irreparable.

THE COURT: And that's Justice Alito's decision in the case about -- I don't have the name in front of me, but last month about the children's books.

MR. SCHOENFELD: *Mahmoud v. Taylor*.

THE COURT: That also reiterated the *Elrod* standard for First Amendment rights.

So on the First Amendment, I understand the issue to be a merits issue on substantial -- I'm not sure "merits" is the right word -- but on the first prong of the preliminary injunction, whether they've made the necessary substantial likelihood of success or not. So let's put that aside. That's the last hour and a half that I still need to figure through.

On to the other types of harm, the two harms that are out there are that the clinics might close and that -- the patient harm. And I had cited the patient harm in the temporary restraining order. You pointed out that harm to third parties, they're not here. They haven't filed a class action. I should consider that if I consider it at all under public interests, but not as irreparable harm.

Are we on the same page here? And you're

disagreeing with that?

MR. SCHOENFELD: Yeah, so we rely on *Elrod.* We rely on the harm to the providers, not simply ceasing to provide care, but the disruption in relationships that they've developed over time. So we rely primarily on that. Sorry.

With respect to the patient harm, there is case law from this district in *Mediplex*, which we cite, which says that when the interests of the third parties and the parties before the Court are so inextricably bound up, you can consider it for purposes of irreparable harm. And I think there's a number of cases in the healthcare context that make clear that you can consider it as a factor.

We win even if you ignore it entirely and consider it just on the equities as between the public interest and the government's interest in enforcing the statute. We win because of the First Amendment interests and the disruption to the provider relationship. The Court can permissibly consider it. If you want to not consider it, we still win on a showing of irreparable harm.

THE COURT: Okay. I haven't read the cases that you just mentioned, but I will go back and look. But let's look at the harm to the providers.

In my prior life, I was -- I did a lot of employment law. And if an individual has a -- is fired

without cause unlawfully, violation of any statute up and down, and now they are about to lose their house and they come in and ask for a preliminary injunction because they're about to lose their house, they don't get it. And the law is pretty clear that, regardless of the reality of the situation, the law just doesn't recognize it. It's a mechanical --

MR. SCHOENFELD: Yeah.

THE COURT: It has money. You can get back money. Even though the money -- even though the clinic is now -- well, if the clinic's closed, we might be in a different circumstance. But even though the clinic has now turned away a lot of patients, you might have lost your house, but tough on you.

Why isn't she right?

MR. SCHOENFELD: There is First Amendment case law, there's case law -- sorry -- First Circuit case law -- I apologize -- not a merits issue. There's First Circuit case law and there's case law elsewhere that says in the context of healthcare, the disruption of the relationship between the provider and the patient is irreparable harm.

The loss of continuity of care, the loss of relationships, the loss of the good will, the obliteration of clinics that will not be able to reconstitute themselves if they lay off employees or if they close entirely is manifest

irreparable harm. No amount of money that the government would be able to provide to Planned Parenthood members at the end of this litigation will ever remedy any of those injuries.

And it's just different in any case when you're dealing with back pay and front pay, no matter the amount of the back pay or front pay, no matter the consequence for an individual employee.

THE COURT: So I think that, first of all, your client isn't -- clients aren't getting paid in real time, right? This is -- someone shows up for services, and they are submitting a claim to the state. And some amount of time later, you get paid that amount of money, right?

MR. SCHOENFELD: Correct. But the -- the healthcare is provided on the assumption, based on years of investment in the program, that they will be reimbursed. And some of my clients have stopped providing care, certain types of care to Medicaid patients, have stopped honoring appointments because of concern that they won't get reimbursed.

THE COURT: I understand that. But isn't the standard that I'm -- isn't the issue here, when it's economic harm that we're talking about, assuming you're right on all of your legal arguments on the merits and assuming at some later juncture I -- you prevail, and those claims that you

have been submitting as you go are now being paid in full, what you're saying is the clinics are having to bet on whether the courts are going to go one way or another?

MR. SCHOENFELD: Correct. And they're making decisions in real time on that basis.

THE COURT: And I'm having to guess whether the courts are going to go one way or another above me.

And what you're saying is I should make that decision rather than your clients, because if your clients are right, then -- and they get that money, I mean, that's the sort of argument; then they'll have the money. And what you're saying is but they have to cancel the appointment not because they can't pay tomorrow's mortgage, but because they -- they think they're not going to be able to pay tomorrow's mortgage because they think that they might lose.

MR. SCHOENFELD: Yeah, I mean, there's hundreds of millions of dollars at stake, and my clients do not lightly disrupt their relationship with patients that they've cultivated trust and good will with for decades.

The reason they are doing this is because they cannot run the risk of incurring liability for submitting reimbursement claims that they may later be penalized by, and they can't be in the business of providing healthcare services when there's no likelihood or no promise of reimbursement.

No -- I mean, the Custer declaration lays this out. No amount of reimbursement for services provided, no amount of interest on top of that will ever allow my patients to restore the status quo. They will never be put back in the position they were in in terms of the relationship with patients --

THE COURT: But isn't that because they're making the choice right now to not take the risk?

MR. SCHOENFELD: This is not a self-inflicted wound.

THE COURT: I understand that, and I'm not trying to be flippant here.

MR. SCHOENFELD: No, I understand.

THE COURT: But if -- you don't disagree with the government's description of how funding is -- comes down. So this isn't a question where you're saying to me, if we don't get this check on Friday, we lose the house, right? There's nothing happening on Friday or Saturday or next week.

MR. SCHOENFELD: I mean, some of this --

THE COURT: The way they've described this, you wouldn't be seeing the money for a while anyway.

MR. SCHOENFELD: I don't think that's true. Some of this money would be coming in before October 1st. I think what the government referred to is an outside two-year limitation on submitting reimbursements, but some of this

money would be coming through the door on a more regular basis, including before October 1st.

THE COURT: So if you submit the claims and the state pays them, then what happens?

MR. SCHOENFELD: Well, then, number one, we are incurring the possibility of False Claims Act --

THE COURT: No, you submit the claims with the proviso on the top that says, "We're submitting it because we think the statute is unconstitutional."

MR. SCHOENFELD: I wish it were the case that that provided adequate insurance, but it doesn't, I think, under pretty well-settled case law. I don't think that would provide adequate security here. And if the government wants to make that representation both as to state and federal False Claims Act liability, that's something we could obviously consider, but it's simply not the case.

These are kind of revolving lines. The money is coming in the door when the services are provided. The possibility that the government is either going to claw the money back at the end of the day because the services were provided under a time period where we are deemed to be a prohibited entity or that the money is never reimbursed for states that aren't providing it, the only reason states are continuing to provide it now is because CMS provided a letter after the Court entered the TRO. We have no idea what's

going to happen, but the likelihood of harm and the harm being irreparable --

THE COURT: I'm sorry. Why are you -- you're continuing to get money for services provided through right now, these two weeks. Is that what you're talking about?

MR. SCHOENFELD: Yeah, as a result of the TRO. I don't know what the case would be if there were no TRO and it hadn't been distributed by CMS to the state directors of Medicaid.

In the absence of some injunction where both the federal government and the state government are free to deny Medicaid payments -- and maybe that would be reversed at some point in the future -- we've described to you in detail exactly what will happen on the ground.

And the fact that we are being put to the choice of serving our patients or foregoing that money is not a choice that the -- that the government is constitutionally permitted to put us to.

The harm here -- I mean, again, I think the harm in terms of the disruption of services, the disruption of the relationships, that is the natural consequence that is the desired intent of Congress. And so if the question is whether that harm is irreparable or not, I don't think there's any case that --

THE COURT: So the problem -- the problem with what

you're saying, I think, is if it's the desired intent of Congress to take this money away and that's upheld by the courts, you lose the money. That's the reality.

And so the question that I have to figure out is, one, substantial likelihood of success, and so I would be saying and you would be saying we believe as we stand here that this is absolutely going our way or very high percentage chance going our way.

If I don't get to that level of very high chance it goes away, then -- I mean, the reason that standard is so high, then in terms of irreparable harm, why aren't we just under this normal rule that, even though the reality on the ground is that all of these services are going to be deprived -- your patients are going to lose out on these services, why isn't the answer, "Oh, well, you do the work if you want to, and then you can get the claim in. You believe you really are going to win it, so it's not that bad a risk"?

MR. SCHOENFELD: Because the PI standard, the PI doctrine doesn't require us to make that choice. *Ex parte Young* makes very clear that we are entitled to challenge an unconstitutional act without subjecting us, ourselves, to the penalty.

And the standard has evolved in such a way to make sure that if we make the requisite showing -- sorry -- if we make the requisite showing that we are substantially likely

to succeed on the merits of our claims, we are entitled to ensure that no harm that will be irreparable, that is irreparable, is one that we have to endure rather than vindicate our constitutional rights.

If there's money at the end of the day that puts us in exactly the status quo ante, I agree; we do not have a right to a preliminary injunction. If we are able to demonstrate to the Court's satisfaction that this is not merely about money and no amount of money will ever restore us to the position we were in before this enactment, then we are entitled to a preliminary injunction.

THE COURT: I -- that -- this is -- I don't think that's quite the test, of restoring you in the exact same position or not. And that's my example about the -- I probably seemed like I was off on a strange tangent, but that's my example about people lose their house; that the courts don't protect you even though that may be the outcome, unless you can show, essentially, corporate death or, you know, that it's not just your services are going to be reduced, it's not just that you're not going to be able to get this product out in a case, it's not just that you are really hamstrung for the long haul. That's not the test, unfortunately.

Isn't the test either that there's some injury that can't be compensated through money or that the entire

business goes out?

MR. SCHOENFELD: I don't think it's quite that clear. I don't think the test is corporate death. I think the test is irreparable harm. And in this particular context, courts have repeatedly recognized that this type of injury, the substantial disruption and the provision of care by long-term healthcare providers invested in their communities to these patients -- and there's no dispute in the record that that is actually going to happen and is, in fact, happening right now.

I don't think there's any dispute that that has traditionally satisfied the irreparable harm standard. And I don't think you're required to show that the clinics are going to close down. But what we have shown you through the record is that employees are going to be laid off and they're never going to be recuperated by the organizations. These are employees who have known these patients for decades and have provided care.

I think those are precisely the types of irreparable harm, particularly in this context, that courts have routinely recognized satisfy the requirements.

I also think -- I mean, not to quibble with the hypothetical, I do think there are cases where if someone is going to lose their house, they may get an injunction because of the irreplaceability of real property. It happens in the

mortgage foreclosure context.

My only point -- again, we don't need to argue about that. My only point is where there is something unique about the relationship, courts are willing to find irreparable harm. And in the doctor-patient relationship, these providers have a unique, irreplaceable, essentially uninterruptible relationship with their patients.

THE COURT: So it seemed like the standard here used to be that I would need to make my evaluation of those harms and substantial risk, substantial likelihood, I would need to make that based on the record. And the appellate courts would review that on an abuse of discretion standard.

Do you think that is currently the state of law?

MR. SCHOENFELD: That is the way the law is currently written. And I think that the -- there is ample support in the record before this Court for both likelihood of success on the merits and irreparable harm. And if the Court were to reach that conclusion on any or all of our claims and find irreparable harm, I'm very confident that, under the governing law, it would be affirmed by the First Circuit.

THE COURT: And then?

MR. SCHOENFELD: Your Honor, I think the point is we are right on the law. We have made the requisite factual showing, and we are entitled, certainly, before Your Honor

for preliminary injunction.

And I think that's true under governing Supreme Court case law as well. I think if you look at any of the cases governing any of the claims here, we come very squarely within the constitutional provision and very squarely within the requirements for a preliminary injunction.

THE COURT: What is your response to the argument regarding the destruction of the patient relationships?

MS. HALL: Your Honor, I think there are two responses to that. First is that, as Your Honor asserted, the plaintiffs here are electing --

THE COURT: I'm not asserting anything here. I'm just pushing both of you.

MS. HALL: Understood, Your Honor. I'll certainly rephrase that.

As was just discussed, there is a -- the plaintiffs here are electing to disrupt the plaintiff -- the patient relationships by ceasing to provide care. But if they ultimately prevail on the merits, if they are correct about their legal theory, the theory that they are pressing and that they assert is substantially likely to succeed, at the end of the litigation, then they will be able to get all of the reimbursements back for the services that they provide.

So any disruption to the patient relationship is something that they are taking on in order to hedge against

not prevailing.

But what matters for irreparable harm is whether it will not be able to be remedied if they ultimately prevail at the end of the litigation. And that, itself, is -- demonstrates that the reimbursements are sufficient and that any action that the plaintiffs take that foregoes those reimbursements by deciding not to provide care, that is something that they are electing to do. That is a path that they are choosing to take.

And they could, instead, kind of put their money where their mouth is and go ahead and provide the procedures and the services that they assert they are legally entitled to provide. And if they prevail at the end of the litigation, then they will be able to receive reimbursement for those services.

A preliminary injunction is not meant to give them insurance in case they're wrong. A preliminary injunction is meant to protect them in case they are right.

THE COURT: I want to switch gears for one minute, and then I'm going to let you both wrap it up.

You described -- the defendants described this piece of legislation as reallocation of funds. And I understood the argument to be that the government would prefer to pay healthcare providers that don't perform abortions also instead of supporting healthcare providers

that do perform abortion; and so, therefore, these same funds, instead of going there, will go somewhere else.

Am I understanding that correctly?

MS. HALL: Broadly, yes, Your Honor.

THE COURT: Okay. So there's a final provision of this, Section 71113, in which allocates an additional $1 million to implement the section.

What's that for?

MS. HALL: Your Honor, as I understand it, that can be spent by the HHS and CMS in order to, for example, put together guidance on how this is implemented, perhaps to police this. You know, if the law's upheld, there's no injunction, then they're going to need to investigate the sorts of forms that are submitted.

As I understand it, and I'll admit this is not incredibly detailed, the current -- the current forms that are submitted to CMS and HHS don't provide all of the information that might be helpful in order to effectuate this provision. And so there might be need to be new forms developed, that sort of thing.

And so there's an allocation so that CMS can take whatever steps are necessary to ensure that it can, in fact, ensure that federal funds are not going to these entities. So that may involve just, you know, reporting requirements, reviewing submissions from states more closely or in a

different way than they might otherwise.

THE COURT: Okay. So it's not a cost-neutral reallocating? The government is spending an additional million dollars to take the work from these clinics and moving them to other clinics?

MS. HALL: Certainly, I don't know whether CMS will spend that full amount, but Congress is entitled to make a judgment that it wishes to expend money in order to ensure that it's not subsidizing --

THE COURT: I just -- you know, when I'm trying to figure out what the statute is, and you described it as reallocating money, it's reallocating and spending more money to move money from places that some of which provide abortions and some of which are affiliated with Planned Parenthood to other facilities.

MS. HALL: Certainly. Congress has appropriated funds in order to ensure that the agency tasked with effectuating its --

THE COURT: I'm not saying they can't do it. I'm just trying to understand what they did. That's all.

MS. HALL: That's my understanding, yes, Your Honor.

THE COURT: Yes?

MR. SCHOENFELD: I would just look at Professor Brindis's report, which makes quite clear that

Congress won't be able to do that, which I think goes to the irreparability of the harm and the public interest.

THE COURT: Won't be able to?

MR. SCHOENFELD: To find providers willing to provide care, capable of providing care to these communities without Planned Parenthood.

THE COURT: Yeah, no, I understand that. But, then, maybe Congress's intent here was to save money on Medicaid and not pay for family planning.

I mean, I'm a little puzzled by this. I have to tell you this. This idea that we're going to stop abortions, that we're going to stop abortions for -- essentially, we're going to stop abortions for poor people, we're going to stop abortions when the person is an essential community provider, primarily engaged in family planning services, reproductive health and related care and is a nonprofit, but Congress decided not to stop abortions when the money is going to a for-profit abortion provider or a facility that doesn't primarily provide -- is not an essential community provider, I mean, it just seems essentially what we're saying is -- what this is saying is that Congress is -- the reason for these differences is Congress paying for -- doesn't want to have funds go to providers that provide family planning services, reproductive health, and related medical care unrelated to abortions to poor people.

MR. SCHOENFELD: I agree with you, Your Honor. And the only point that I want to underscore, Your Honor, sort of using "family planning" as, I think, a shorthand here, we're talking about a lot of cancer screenings. We're talking about a lot of basic healthcare that's provided by Planned Parenthood through the Medicaid program.

THE COURT: And Medicaid, I believe you both -- there's no disagreement; Medicaid is required to cover contraception.

MS. HALL: There's no disagreement.

THE COURT: By statute, not by reg.

MR. SCHOENFELD: Correct.

THE COURT: Okay. We need to wrap this up. I will give each of you a tiny closing argument and try not to interrupt you.

MR. SCHOENFELD: Sure, Your Honor.

I think the argument has been very comprehensive, and I appreciate the Court's, you know, thoughtful engagement here. I would just underscore two points.

The first one is I think what became clear through our colloquy and Your Honor's colloquy with the government is that this is not an abortion regulation. If it were an abortion regulation, it would be written differently, and we would find ourselves in a different place.

The statute is trying to do more, and it's not --

you don't have to scratch your head and think about what the statute is trying to do. It's clear from the face of the statute. It's clear from the legislative context. It's clear from the historical context. It's clear from the legislature's own mouths, all of which the Court can consider, even though it need not, to reach the conclusion that what is happening here is that Planned Parenthood and Planned Parenthood alone, not notwithstanding the presence of two other entities, Planned Parenthood alone is being singled out.

And whatever flavor you choose to adopt to figure out why that is constitutionally impermissible, bill of attainder, equal protection, or First Amendment, the government cannot do that. And that is true with respect to the entire federation and all of its members.

The government doesn't get to say I dislike you because you come together to reach a broader audience and stand in solidarity with each other in support of abortion rights and then choose to disqualify you from a program that has nothing to do with abortion. So that's my sort of summary on the merits.

On the irreparable harm, I would encourage Your Honor to look at the -- I'm sure you have, but I just want to bring you back to the cases we cite in our brief, all of which make clear that while it is generally true that as a

loss of money is not an irreparable harm, there are circumstances like those present here where the loss of services and the direct immediate impact on the plaintiff constitutes an irreparable harm.

And we've cited recent cases from this district, we've cited recent cases from this circuit, and we've cited other cases in the healthcare context, all of which make that point, which I think ought to be obvious.

No matter how much money the government ever decides to distribute to Planned Parenthood affiliates, they will never be able to find themselves in the position they found themselves before this statute was enacted.

And contrary to what the government says, there is no constitutional requirement and there is no impediment in Rule 65 or the case law to us asserting our constitutional rights and preserving the status quo if we can make the requisite showing.

My clients are not required to gamble their livelihoods, their relationships, and their patients' lives in order to vindicate their obvious constitutional rights.

Thank you, Your Honor.

MS. HALL: Your Honor, the law at issue in this case is an exercise of Congress's core -- thank you -- core power of the purse. It's a spending regulation, and it restricts who and what Congress will subsidize. That's a

core authority under Article I, and Congress -- both houses of Congress and the President came together, all three democratically elected bodies in the government, to enact that restriction on federal funds on behalf of the American taxpayer.

That should not be displaced lightly. And plaintiffs have failed to present the level of evidence that would be required to demonstrate that this -- this law was enacted with animus, that it was enacted to target Planned Parenthood. We did not get a chance to talk about this extensively, but there are other entities other than Planned Parenthood that may be subject to the law as well as we put forth in the Snyder declaration. And so there's really no evidence that this law was, in fact, designed to target Planned Parenthood.

The plaintiffs assert that there's ample legislative evidence that it was, in fact, not only designed to target Planned Parenthood, but, in fact, to target Planned Parenthood's shared advocacy on behalf of abortion and not provision of abortion. But every legislative statement that they put forth in the record is about providing abortions, which is not protected activity.

Evidence that Congress was trying to avoid federal funds, federal taxpayer money from going to entities that provide abortions is not the same as targeting First

Amendment activity that is advocating for abortion.

And, again, the use of a corporate form, a standard corporate definition of "affiliate," does not render the statute unconstitutional by infringing on freedom of association.

As we've discussed, the plaintiffs can continue to advocate. They continue to put together ad campaigns. They can lobby -- they can -- there are, obviously, restrictions on lobbying itself, but they can advocate to Congress that Congress pass certain policies. None of that is restricted by this law, and none of that is restricted by any notion of affiliate.

"Affiliate" is not a term that is used to encompass any particular association. And as I mentioned, you know, Planned Parenthood entities could choose to associate for protected speech purposes with many other entities, including the other entities, Maine Family Planning and Health Imperatives, that might be covered by the statute. And, again, that's premature.

They could associate with those entities for the same expressive purposes that they say is the reason that they're members of Planned Parenthood. And without any corporate relationship, there's no issue.

So, again, I think that plaintiffs are really relying on this idea that affiliation is the same as

association. That simply is not true. It has no basis in the law.

Secondly, as to irreparable harm, again, irreparable harm is meant to ensure that if plaintiffs prevail at the end of litigation, they have not suffered irreparable harm. Their choice not to provide care because they may not prevail at the end of litigation does not cause them irreparable harm.

So for these reasons, Your Honor, the government submits that there is no basis to enter a preliminary injunction enjoining an act of Congress, signed by the President, and has been in effect for less than two weeks without opportunity to apply at all to the members --

THE COURT: It's actually been restrained for less than two weeks, but --

MS. HALL: That's right, Your Honor. It has, in fact, been restrained; and the agencies certainly have been respecting that injunction.

But, again, the law -- the rest of the law has been in effect for less than two weeks. This is very new. There's been no opportunity for the agency to set forth the definition of "affiliate," to begin that process. And for that reason, among all the others in our briefing, there's no basis for a preliminary injunction here.

Thank you.

THE COURT: I will take this back and get something out in writing.

I would like set a schedule for litigation of this case going forward. I understand you don't know what you're going to do till you know what I'm going to do. But let me ask you: Two weeks after my decision is issued, if you can confer and give me a proposed schedule for how this litigation will unfold?

MR. SCHOENFELD: Absolutely, Your Honor.

MS. HALL: Certainly, Your Honor.

MR. SCHOENFELD: I know Your Honor doesn't need to be reminded of this, but the TRO expires on Monday.

THE COURT: I am aware.

MR. SCHOENFELD: Okay. I felt obligated to say it. I'm sure Your Honor is on top of it.

THE COURT: If the government was amenable to extending the time and I could spend my weekend with my family, I would appreciate that. I don't imagine that I have too much leeway there, but --

MS. HALL: Your Honor, the government does not consent to an extension of the TRO.

THE COURT: That's where we are.

MR. SCHOENFELD: Thank you, Your Honor.

THE COURT: I will look forward to your statement in two weeks, and you'll have my decision on Monday.

MR. SCHOENFELD: So just to be clear, like an ordinary kind of Rule 16, Rule 26 statement?

THE COURT: Yes. I realize I'm early in the process, and I also realize this is an issue where the plaintiffs are asserting First Amendment rights and, et cetera. And if I do end up issuing a preliminary injunction, the government will be fighting that.

So see what I've put out, but then give me the schedule based on what I -- what I've done of how you think, regardless of how I go on that decision, what happens. That's not the decision on the merits and the schedule for how we proceed. I would appreciate it.

I do recognize that I'm early in the game. I just think there's some urgency as evidenced by this filing. And I would imagine -- I mean, frankly, whichever way I go, I can imagine that there will be an appeal on either side. So that doesn't stop the underlying litigation.

Thank you.

MR. SCHOENFELD: Thank you, Your Honor.

MS. HALL: Thank you, Your Honor.

THE DEPUTY CLERK: We are in recess.

(Court in recess at 11:03 a.m.)

CERTIFICATE OF OFFICIAL REPORTER

I, Robert W. Paschal, Registered Merit Reporter and Certified Realtime Reporter, in and for the United States District Court for the District of Massachusetts, do hereby certify that pursuant to Section 753, Title 28, United States Code, the foregoing pages are a true and correct transcript of the stenographically reported proceedings held in the above-entitled matter and that the transcript page format is in conformance with the regulations of the Judicial Conference of the United States.

Dated this 28th day of July, 2025.

/s/ Robert W. Paschal

ROBERT W. PASCHAL, RMR, CRR
Official Court Reporter

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

PLANNED PARENTHOOD FEDERATION OF AMERICA, *et al.*,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

Case No. 1:25-cv-11913

NOTICE OF APPEAL OF PRELIMINARY INJUNCTION

PLEASE TAKE NOTICE that Defendants hereby appeal to the United States Court of Appeals for the First Circuit from the Court's July 21, 2025, Memorandum & Order, *see* ECF No. 62.

Dated: July 22, 2025

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that this document filed through the CM/ECF system will be sent electronically to the registered participants as identified on the NEF.

Dated: July 22, 2025

/s/ *Emily M. Hall*
Emily M. Hall

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., *et al.*, Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, Defendants.	No. 1:25-cv-11913-IT

NOTICE OF APPEAL

Please take notice that Defendants hereby appeal to the United States Court of Appeals for the First Circuit from this Court's July 28, 2025 memorandum opinion and order, Dkt. No. 69.

Dated: August 5, 2025

Respectfully submitted,

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UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS, and PLANNED PARENTHOOD ASSOCIATION OF UTAH, Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as Secretary of the U.S. Department of Health and Human Services, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, MEHMET OZ, in his official capacity as Administrator of the Centers for Medicare & Medicaid Services, and CENTERS FOR MEDICARE & MEDICAID SERVICES, Defendants.	*	Civil Action No. 1:25-cv-11913-IT

MEMORANDUM & ORDER

August 29, 2025

TALWANI, D.J.

Pending before the court is Defendants' Motion to Stay Preliminary Injunctions Pending Appeal [Doc. No. 84]. Plaintiffs Planned Parenthood Federation of America, Inc. ("Planned Parenthood Federation"), Planned Parenthood League of Massachusetts ("Planned Parenthood Massachusetts"), and Planned Parenthood Association of Utah ("Planned Parenthood Utah") assert that Defendants have not carried their burden to show that a stay is warranted. See generally Opp'n [Doc. No. 92]. For the reasons set forth below, Defendants' Motion [Doc. No. 84] is DENIED.

I. Background

The court incorporates by reference the factual findings set forth in its Memorandum & Order [Doc. No. 69].

To summarize, on July 4, 2025, the President signed into law An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14 ("the 2025 Reconciliation Act"), Pub. L. No. 119-21, 139 Stat. 72 (2025). Mem. & Order 23 [Doc. No. 69]. Section 71113(a) of the 2025 Reconciliation Act directs that certain "prohibited entities" may not receive federal Medicaid reimbursements for a one-year period beginning on the law's effective date. Pub. L. No. 119-21, § 71113(a), 139 Stat. 72, 300 (July 4, 2025). Section 71113(b)(1) defines a "prohibited entity" as:

> an entity, including its affiliates, subsidiaries, successors, and clinics—
>
> (A) that, as of the first day of the first quarter beginning after the date of enactment of this Act—
>
> (i) is an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code;
>
> (ii) is an essential community provider described in section 156.235 of title 45, Code of Federal Regulations (as in effect on the date of enactment of this Act), that is primarily engaged in family planning services, reproductive health, and related medical care; and
>
> (iii) provides for abortions, other than an abortion-
>
> (I) if the pregnancy is the result of an act of rape or incest; or
>
> (II) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed; and
>
> (B) for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act for medical assistance furnished in fiscal year 2023 made directly, or by a covered organization, to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded $800,000.

Id. § 71113(b)(1). The definition of "prohibited entity" captures all Planned Parenthood Federation Members, including some that do not perform abortion and/or did not receive more than $800,000 in Medicaid reimbursements during fiscal year 2023. Mem. & Order 13–14 [Doc. No. 69]; Custer Decl. ¶ 47 [Doc. No. 5-1]; Lee Decl. ¶ 29 [Doc. No. 5-2]. The definition also covers two entities that are not Planned Parenthood Federation Members. See Mem. & Order 14; Snyder Decl. ¶ 6 [Doc. No. 53-2].

Plaintiffs filed this action on July 7, 2025, alleging that Section 71113 violates the United States Constitution by subjecting Planned Parenthood Federation and its Members to a bill of attainder, by retaliating against them in violation of the First Amendment, and by denying them equal protection of the law. See Compl. ¶¶ 130–53 [Doc. No. 1]. Plaintiffs also alleged that where Planned Parenthood Members that do not perform abortion and/or did not receive more than $800,000 in Medicaid reimbursements during fiscal year 2023 would be covered based on their affiliation with other Members, Section 71113 imposes an unconstitutional condition on their First Amendment rights and is unconstitutionally vague in violation of the Fifth Amendment. Id. ¶¶ 164–75.

Plaintiffs also filed an Emergency Motion for a Temporary Restraining Order and Preliminary Injunction [Doc. No. 4]. In opposing Plaintiffs' Motion [Doc. No. 4], Defendants requested that the court stay any injunctive relief pending appeal. Defs.' Mem. 44 [Doc. No. 53]. On July 21, 2025, the court granted Plaintiffs' request for a Preliminary Injunction in part and enjoined Defendants from enforcing or otherwise applying Section 71113 against Planned Parenthood Federation Members, including Planned Parenthood Utah, who will not provide abortion services as of October 1, 2025, or for whom the total amount of Federal and State expenditures under the Medicaid program furnished in fiscal year 2023 made directly to them did

not exceed $800,000. Mem. & Order 35 [Doc. No. 62]. The court denied Defendants' request to stay this injunction pending appeal. Id. 33–35. Defendants appealed this ruling the following day, Notice of Appeal [Doc. No. 63], but did not seek a stay from the First Circuit at that time.

On July 28, the court granted the remainder of Plaintiffs' request for injunctive relief. The court enjoined Defendants from enforcing or applying Section 71113 against Planned Parenthood Utah, Planned Parenthood Massachusetts, and all other Planned Parenthood Federation Members. Mem. & Order 58 [Doc. No. 69]. The court again denied Defendants' request for a stay pending appeal, finding that Defendants did not carry their burden to show that a stay was warranted. Id. at 57. Defendants appealed that ruling on August 5, 2025. Notice of Appeal [Doc. No. 75]. Again, Defendants did not seek a stay from the First Circuit at that time.

On August 7, 2025, Defendants filed the pending standalone Motion to Stay Preliminary Injunctions Pending Appeal [Doc. No. 84], which requested a stay of the court's July 21, 2025 Memorandum & Order [Doc. No. 62] and July 28, 2025 Memorandum & Order [Doc. No. 69] pending appeal to the United States Court of Appeals for the First Circuit. Mot. 1 [Doc. No. 84]. On August 11, 2025, the court ordered Plaintiffs to respond to Defendants' Motion [Doc. No. 84] no later than August 21, 2025, in accordance with Local Rule 7.1(b)(2). See Elec. Order [Doc. No. 87].

That evening, Defendants sought a stay in the First Circuit. See Appellants' Mot. for Stay Pending Appeal, Planned Parenthood Federation of America, Inc., v. Robert F. Kennedy, Jr., No. 25-1698 (1st Cir., Aug. 11, 2025). Defendants did not withdraw the Motion [Doc. No. 84] pending before this court, however, and on August 19, 2025, the First Circuit denied Defendants' stay request without prejudice. See Order 1 [Doc. No. 89].

On Thursday, August 20, 2025, Defendants notified the court that they would not seek leave to file a Reply in support of the pending Motion [Doc. No. 84]. Defs.' Notice Regarding Stay Mot. [Doc. No. 91]. Defendants requested that the court rule on their motion no later than Monday, August 25, 2025, "so that, if needed, Defendants may seek relief from the First Circuit and, if further relief is necessary, from the Supreme Court in advance of October 1, 2025[.]" Id. at 3. Although Defendants initiated appellate proceedings on July 22, 2025, see Notice of Appeal [Doc. No. 63], and now seek a stay, to date they have not sought expedited review from the First Circuit of the preliminary injunction orders.

II. Standard of Review

A district court may stay injunctive relief while an appeal is pending. Fed. R. Civ. P. 62(d). However, "[a] stay is an intrusion into the ordinary processes of administration and judicial review." Nken v. Holder, 556 U.S. 418, 427 (2009) (internal quotations and citation omitted); accord New York v. Trump, 133 F.4th 51, 65 (1st Cir. 2025). Accordingly, "[a] stay is not a matter of right, even if irreparable injury might otherwise result." Nken, 556 U.S. at 433 (citation omitted).

"[T]he party seeking a stay—here, the Government—bears the burden of proving that the circumstances justify one." New Jersey v. Trump, 131 F.4th 27, 34 (1st Cir. 2025). In determining whether the circumstances warrant a stay, courts consider

> (1) whether the stay applicant has made a strong showing that he is likely to succeed on the merits; (2) whether the applicant will be irreparably injured absent a stay; (3) whether issuance of the stay will substantially injure the other parties interested in the proceeding; and (4) where the public interest lies.

Nken, 556 U.S. at 426.

"The first two factors . . . are the most critical. It is not enough that the [applicant's] chance of success on the merits be better than negligible." Id. at 434 (internal quotations and

citation omitted). Similarly, "simply showing some possibility of irreparable injury fails to satisfy the second factor." Id. at 434–35 (internal quotations and citation omitted). Courts assess the harm to other interested parties and weigh the public interest "[o]nce an applicant satisfies the first two factors." Id. at 435.

III. Discussion

A. *Defendants' Likelihood of Success on the Merits*

In the orders on appeal, the court concluded that Plaintiffs demonstrated a substantial likelihood of success on their claims that Section 71113 unconstitutionally conditions Medicaid funding on Planned Parenthood Members foregoing associational rights, violates Planned Parenthood Members' right to equal protection, and subjects Planned Parenthood Federation and its Members to a bill of attainder. Mem. & Order 23–49 [Doc. No. 69]; see also Mem. & Order 16–28 [Doc. No. 62] (concluding Section 71113 unconstitutionally conditions Medicaid funding on Planned Parenthood Members foregoing associational rights and violates Planned Parenthood Members' right to equal protection). Defendants argue that they are likely to succeed on the merits on appeal, focusing primarily on their contention that Section 71113 is not a bill of attainder. See Mem. ISO Mot. to Stay 3–9 [Doc. No. 85]. As explained below, Defendants have not "made a strong showing" that their challenges are likely to prevail on appeal as to any of the grounds on which Plaintiffs have thus far shown a likelihood of success, let alone all three.

1. The First Amendment and Equal Protection Claims

a. The Court's Original Findings

Defendants argue that Section 71113's "reference to an entity's 'affiliates' . . . in defining a 'prohibited entity' does not transform the entire provision into an intrusion on the First Amendment's protection of expressive association." Mem. ISO Mot. to Stay 9 [Doc. No. 85]. In their construct, "Section 71113 does not require Medicaid recipients (i.e. providers) to refrain

from any form of expressive activity." Mem. ISO Mot. to Stay 12 [Doc. No. 85]. But Defendants ignore that Section 71113 does exactly that where it requires Members to disassociate from each other to continue receiving Medicaid reimbursement. See Mem. & Order 26, 28, 45 [Doc. No. 69].

As the court explained, "[m]embership in Planned Parenthood Federation—and corresponding affiliation with other Members—is . . . part and parcel with Planned Parenthood Members' associational expression." Mem. & Order 27 [Doc. No. 69]. Defendants have asserted that "HHS and CMS could permissibly conclude . . . that [Planned Parenthood Federation] members are all 'affiliates' within the meaning of the statute." Defs.' Mem. 29 [Doc. No. 53]. Consequently, Planned Parenthood Members who do not perform abortions must relinquish their affiliation with other Planned Parenthood Members, and thus with Planned Parenthood Federation, to avoid Section 71113's coverage. Where the law discourages membership in Planned Parenthood Federation, it diminishes Members' associational expression. See NAACP v. Claiborne Hardware Co., 458 U.S. 886, 908 (1982) ("Effective advocacy of both public and private points of view, particularly controversial ones, is undeniably enhanced by group association.") (quoting NAACP v. Alabama ex rel. Patterson, 357 U.S. 449, 460 (1958)). And expressive association itself is protected by the First Amendment. Roberts v. U.S. Jaycees, 468 U.S. 609, 622 (1984) (explaining Supreme Court has "long understood as implicit in the right to engage in activities protected by the First Amendment a corresponding right to associate with others in pursuit of a wide variety of political, social, economic, educational, religious, and cultural ends."). Where Section 71113 discourages Planned Parenthood Members from "affiliating" with each other via Membership in Planned Parenthood Federation, it is irrelevant that Section 71113 does not prevent Members from "collaborat[ing] for the purpose of advocacy,

prais[ing] or endors[ing] each other publicly, participat[ing] in events, or issu[ing] joint press releases." Mem. ISO Mot. to Stay 12 [Doc. No. 85].

Defendants suggest that Section 71113 at most creates a First Amendment concern only regarding its application "to a handful of unusual Planned Parenthood members." Mem. ISO Mot. to Stay 13 [Doc. No. 85]. But the court has explained that Section 71113 also impinges Planned Parenthood Federation's associational right. See Mem. & Order 37, 45, 52 [Doc. No. 69]. As Defendants have pointed out, "[a]ny [Planned Parenthood Federation] member can . . . remove itself from the provision's scope by . . . ceasing to provide for abortions and disaffiliating with entities that do." Defs.' Mem. 11 [Doc. No. 53]; see also Mem. & Order 34, 39, 45 [Doc. No. 69] (discussing disaffiliation requirement). But because disaffiliating from other Members requires disassociating from Planned Parenthood Federation, Section 71113's application on the basis of affiliation inhibits Planned Parenthood Federation's ability to engage in collective advocacy. The law thus "impinges on Planned Parenthood Federation's . . . right of association." Mem. & Order 45 [Doc. No. 69]; see also Mem. & Order 30 [Doc. No. 62] ("[W]here Section 71113 burdens Non-qualifying Members' affiliation with other Planned Parenthood Members, it diminishes Planned Parenthood Federation's and those Members' associational expression and causes First Amendment injury.").

Because Section 71113 burdens Planned Parenthood Federation and its Members' associational expression, the court concluded that Section 71113 is subject to strict scrutiny. Mem. & Order 45 [Doc. No. 69]. Laws that impinge on fundamental rights, including First Amendment rights, "will only be upheld if 'precisely tailored to serve a compelling governmental interest.'" Rocket Learning, Inc. v. Rivera-Sanchez, 715 F.3d 1, 9 n.6 (1st Cir. 2013) (quoting Plyler v. Doe, 457 U.S. 202, 217(1982)); Mem. & Order 45–47 [Doc. No. 69].

Although Defendants contest the court's alternative conclusion that Section 71113 is unlikely to survive rational basis review, see Mem. ISO Mot. to Stay 14 [Doc. No. 85], they do not contend that "halting funding to certain large abortion providers" constitutes a compelling government interest, see Mem. ISO Mot. to Stay 16 [Doc. No. 85], or that Section 71113 is "precisely tailored" to any compelling interest such that it can survive strict scrutiny.

The court concluded that Plaintiffs are also likely to succeed in establishing that Section 71113 fails rational basis review because Section 71113's conjunctive criteria "affect[] only a small number of abortion providers," "leave[] every other conceivable category [of abortion provider] unaffected," and include Planned Parenthood Members who do not provide abortion. Mem. & Order 47–49 [Doc. No. 69]. Defendants continue to argue that the law's criteria are rational in isolation, suggesting that because essential community providers—which primarily serve low-income, medically underserved individuals—are most likely to have many Medicaid patients, depriving Medicaid funding from only this category of healthcare providers "justif[ies] the administrative burdens associated with identifying prohibited entities." Mem ISO Mot. to Stay 15 [Doc. No. 85]. But it is the criteria in conjunction that single out Planned Parenthood Federation Members (and only two other known entities) for unequal treatment. Mem. & Order 44–45 [Doc. No. 69]. Therefore, Section 71113's conjunctive definition undermines the conceived rational bases for the law notwithstanding justifications for any of the individual criterion. See Mem. & Order 47–49 [Doc. No. 69].

Defendants assert that "halting federal subsidies to one category of abortion providers plainly serves" the goal of reducing abortion. See Mem. ISO Mot. to Stay 14 [Doc. No. 85]. "But discriminatory exclusion . . . is [not] a permissible legislative end." Mem. & Order 48 [Doc. No. 69] (citing Lyng v. Int'l Union, United Auto., Aerospace & Agr. Implement Workers of Am.,

UAW, 485 U.S. 360, 373 (1988) and Romer v. Evans, 517 U.S. 620, 632 (1996)). And as the court detailed, Section 71113 excludes a category of Medicaid programs that is both over and underinclusive such that it likely violates Plaintiffs and Planned Parenthood Members' constitutional right to equal protection under both strict scrutiny and rational basis review. See id. at 44–49.

b. Defendants' New Arguments

Defendants' Memorandum in Support of Motion to Stay [Doc. No. 85] also seeks to justify the law's coverage of "affiliates" as no more than "an incidental burden" on protected expression. Mem. ISO Mot. to Stay 11 [Doc. No. 85] (citing United States v. O'Brien, 391 U.S. 367, 377 (1968) and Arcara v. Cloud Books, Inc., 478 U.S. 697, 705 (1986)). However, Defendants previously asserted only that "the law does not restrict speech or burden association." Defs.' Mem. 34 [Doc. No. 53]; see also id. at 7 ("providing abortions is conduct, not speech); id. at 35 ("Section 71113 . . . does not condition government funding on speech at all."). To the extent Defendants seek to justify the law's burden on protected expression for the first time through their Motion to Stay [Doc. No. 84], their argument is not properly before the court. See Iverson v. City Of Bos., 452 F.3d 94, 103 (1st Cir. 2006) (concluding plaintiff waived argument not presented in opposition to defendant's dispositive motion); cf. Disaster Sols., LLC v. City of Santa Isabel, Puerto Rico, 21 F.4th 1 (1st Cir. 2021) (holding argument waived where not presented prior to post-judgment motion).

The court nonetheless addresses Defendants' new argument in light of the important First Amendment issues at stake. In the cases on which Defendants rely, the Court "has held that when 'speech' and 'nonspeech' elements are combined in the same course of conduct, a sufficiently important governmental interest in regulating the nonspeech element can justify incidental limitations on First Amendment freedoms." O'Brien, 391 U.S. at 376. Instead of regulating one

course of conduct, Section 71113 requires Planned Parenthood Members to refrain from specific activities—including affiliating with Planned Parenthood Federation and Members that provide abortion—to continue engaging in a separate activity—participating in Medicaid programs. Defendants have not articulated why their argument under the O'Brien test will prevail where Plaintiffs' First Amendment claim turns on application of the unconstitutional conditions framework. See Mem. & Order 23–30 [Doc. No. 69].

As the court explained, the Supreme Court has emphasized in unconstitutional conditions cases that permitting regulated entities to use distinct (albeit closely-related) corporate entities to separate federally funded activities from protected expression that Congress chooses not to fund "allows Congress to set conditions with its spending powers without unconstitutionally leveraging the funding." Mem. & Order 28 [Doc. No. 69] (discussing Regan v. Taxation With Representation of Wash., 461 U.S. 540 (1983) and FCC v. League of Women Voters of Cal., 468 U.S. 364 (1984)). But the "affiliates" provision does the opposite; it leverages funding to coerce disaffiliation among Members and from Planned Parenthood Federation.

Defendants acknowledge that in the cases on which the court relied, "the Supreme Court recognized that the resulting First Amendment concerns would be alleviated if the government permitted the regulated entities" to engage in protected expression "through their affiliates." Mem. ISO Mot. to Stay 10 [Doc. No. 85] (citing Regan, 461 U.S. at 543, and FCC, 468 U.S. at 400-01). Defendants argue "[t]hat principle has no bearing here, where Section 71113 does not require Medicaid recipients (i.e. providers) to refrain from any expressive activity." Id. But Section 71113 does exactly that: The law requires Planned Parenthood Members to refrain from affiliating with Members that provide abortions, and that affiliation is for expressive activity. See Mem. & Order 26–27 [Doc. No. 69] (explaining "the record demonstrates that Members'

affiliation via their membership in Planned Parenthood Federation is expressive"). And as this court previously explained, "Section 71113 prohibits the type of dual structure that would have insulated the abortion restriction from an unconstitutional conditions challenge." Mem. & Order 29 [Doc. No. 69].

Even assuming that O'Brien applies, Defendants have not made the requisite showing that the burden on First Amendment rights is permissible here. A government regulation is sufficiently justified if, inter alia, "the incidental restriction on alleged First Amendment freedoms is no greater than is essential to the furtherance of that interest." O'Brien, 391 U.S. at 377 (footnotes omitted) (emphasis added). Defendants make no such showing.

Defendants argue only that the "affiliates" provision is necessary because without it, "a prohibited entity could create subsidiaries or affiliates and then use them to obtain federal Medicaid funds, frustrating Congress' objective of withholding taxpayer dollars from certain large abortion providers." Mem. ISO Mot. to Stay 10 [Doc. No. 85]. But while Defendants focus on evasion of the law through new "subsidiaries" or other entities under a prohibited entity's control, the provision has no such limitation. Instead, it encompasses existing affiliates that do not provide abortion. And there is no indication in the record that Planned Parenthood Members share revenues from Medicaid reimbursements. The result is a restriction on associational freedom that is in no way "essential to the furtherance of [Defendants'] interest" in withholding funds from certain abortion providers, Arcara, 478 U.S. at 703 (quoting O'Brien, 391 U.S. at 377 (footnotes omitted)), and instead imposes a wholly unwarranted burden.

Further, Section 71113 differs in significant respects from the list of statutory provisions Defendants offer to suggest that the term "affiliates" raises no First Amendment concern. See Mem. ISO Mot. to Stay 10–11 [Doc. No. 85]. First, the statutes Defendants identify illustrate that

where Congress seeks to prevent evasion of regulation through related entities, it has done so by carefully defining the relationships at issue to ensure that the statute only applies to organizations related to the regulated entities via "control."[1] In contrast here, Section 71113 does not define or limit the term "affiliates." And while Defendants contend that the term "affiliates" necessarily has the same meaning in Section 71113 as it does in those statutes, Section 71113 does not contain the same limitation. Consistent with the absence of any express limit on the term "affiliates," Defendants have argued that "Planned Parenthood Federations' 'membership

[1] See e.g. 12 U.S.C. § 1841(k) ("For purposes of this chapter [relating to banking regulation], the term 'affiliate' means any company that controls, is controlled by, or is under common control with another company."); 21 U.S.C. § 350g(l)(4)(A) (defining, for purposes of section regarding monitoring and recordkeeping at facilities engaged in food manufacturing and processing, "[t]he term 'affiliate'" as "any facility that controls, is controlled by, or is under common control with another facility"); 26 U.S.C. § 414(b) (treating, for purposes of certain sections of the Internal Revenue Code, "all employees of all corporations which are members of a controlled group of corporations (within the meaning of section 1563(a) . . . as employed by a single employer")) and id. § 1563(a) (defining a "controlled group of corporations" based on stock ownership); 29 U.S.C. § 1301(14) (defining, for purposes of determining the employer for certain plans under ERISA, a "controlled group" to mean a group "under common control" of a person); 15 U.S.C. § 1693o-2(c)(1) (defining, for the purpose of exemption from regulations on interchange fees for electronic debit transactions, "[t]he term 'affiliate'" as "any company that controls, is controlled by, or is under common control with another company"); 7 U.S.C. § 136a-1(i)(E)(ii)(II)(bb) (explaining, for purposes of setting fees for registrants of pesticides, "persons are affiliates of each other if, directly or indirectly, either person controls or has the power to control the other person, or a third person controls or has the power to control both persons"); 16 U.S.C. § 620e(5) (defining, for purposes of statute restricting exports of unprocessed timber from federal lands, "person" subject to restrictions to include "business affiliates where 1 affiliate controls or has the power to control the other or when both are controlled directly or indirectly by a third person"); 42 U.S.C. § 16451(1) (defining, for purposes of statute concerning records costs incurred by a public utility or natural gas company, "[t]he term 'affiliate' of a company" as "any company, 5 percent or more of the outstanding voting securities of which are owned, controlled, or held with power to vote, directly or indirectly, by such company"); cf. 50 U.S.C. § 4611 (explaining, where the President has found a violation of multilateral export control violations by a foreign person, sanctions may be imposed on "any parent, affiliate, subsidiary, and successor entity of the foreign person," except where the President determines that "the parent, affiliate, subsidiary, or successor entity . . . has not knowingly violated the export control regulation violated by the foreign person" and other requirements are met).

standards,' 'accreditation standards,' and 'shared medical standards and guidelines,' would be sufficient to show common control such that Planned Parenthood Members who do not provide abortion could be 'affiliates' of the Planned Parenthood Members who do," Mem. & Order 26 [Doc. 69] (quoting Defs.' Mem. 28 [Doc. No. 53]), even though the record before the court demonstrates that each Planned Parenthood Member is an independent organization that is incorporated and governed separately from other Members, and that each has its own CEO and governance structure. See id. at 8 (citing Custer Decl. ¶ 9 [Doc. No. 5-1]; Lee Decl. ¶ 10 [Doc. No. 5-2]; Ghorbani Decl. ¶¶ 1, 8–9 [Doc. No. 5-3]).

Second, none of the statutes cited by Defendants impact First Amendment protected activity or circumstances in which the affiliation at issue is "part and parcel with . . . associational expression." See Mem. & Order 27 [Doc. No. 69]. Plaintiffs have demonstrated that Planned Parenthood Members' affiliation with each other is expressive. Id. at 26–27. That Congress has used the term "affiliates" in contexts that do not implicate collective advocacy has no bearing on the First Amendment issue here.

2. Defendants' Renewed Bill of Attainder Arguments

Defendants argue that they are likely to prevail on the merits because Section 71113 is not a bill of attainder. Mem. ISO Mot. to Stay 3 [Doc. No. 85]. First, Defendants argue that Section 71113 does not impose punishment, and instead "advances Congress's 'nonpunitive legislative purpose[]' of ending Medicaid funding for certain abortion providers." Id. (quoting Nixon v. Adm'r of Gen. Servs., 433 U.S. 425, 475–76 (1977)). Second, Defendants argue that Section 71113 is not a bill of attainder because it does not single out identifiable individuals. Id. at 6.

The Bill of Attainder Clause prohibits Congress from enacting a law that "legislatively determines guilt and inflicts punishment" on an identifiable party without a judicial trial. Nixon

v. Adm'r of Gen. Servs., 433 U.S. 425, 468 (1977). "The deprivation of any rights, civil or political, previously enjoyed, may be punishment[.]" Cummings v. Missouri, 71 U.S. 277, 320 (1866). The Supreme Court has recognized three necessary inquiries in determining whether a statute imposes punishment: "(1) whether the challenged statute falls within the historical meaning of legislative punishment; (2) whether the statute, 'viewed in terms of the type and severity of burdens imposed, reasonably can be said to further nonpunitive legislative purposes'; and (3) whether the legislative record 'evinces a congressional intent to punish.'" Selective Serv. Sys., 468 U.S. 841, 852 (1984) (quoting Nixon v. Adm'r of Gen. Servs., 433 U.S. 425, 468 (1977)). The determination is ultimately circumstantial, and none of these inquiries are dispositive. See Selective Serv. Sys., 468 U.S. at 852–54.

Defendants contend that "[h]alting the flow of federal Medicaid funds . . . bears no resemblance to the forms of punishment that implicate the Bill of Attainder Clause." Mem. ISO Mot. to Stay 4 [Doc. No. 85]. But in determining that Section 71113 imposes punishment, the court considered not only the deprivation of Medicaid funding, but also the "occupational[] and constitutional harms that the law imposes." Mem. & Order 37 [Doc. No. 69]. The court concluded that "[w]here Section 71113 conditions a specified group's continued participation in Medicaid on Planned Parenthood Members surrendering certain activities" by October 1, 2025, namely ending abortion services and disaffiliating from other Planned Parenthood Members, the law "fits within a historical category of bills of attainder" that required particular parties to "do a given act by a named day" to escape the law's burden. Id. at 38 (collecting sources); see also Gaines v. Buford, 31 Ky. 481, 510 (1833). And because Section 71113 requires Planned Parenthood Members to either stop participating in Medicaid programs or end both legal abortion services and affiliation with other Planned Parenthood Members and Planned

Parenthood Federation, it bars Planned Parenthood Members from participation in Medicaid programs if they continue to affiliate for collective advocacy. See Mem. & Order 38–39 [Doc. No. 69]. It thus bears resemblance to a historical category of bills of attainder that "barr[ed] designated . . . groups from participation in specified employments or vocations." Nixon, 433 U.S. at 474.

Defendants correctly point out that abortion access is no longer constitutionally protected, Mem. ISO Mot. to Stay 7 [Doc. No. 85] (citing Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 232 (2022)), but nothing in the decisions Defendants have appealed turned on an elevated status for abortion rights. That there is no constitutionally protected right to abortion does not leave Planned Parenthood Federation and its Members unprotected by other provisions of the Constitution. Singling out Planned Parenthood Members for exclusion from Medicaid programs so long as they—or any affiliate—continue to provide legal abortion, while allowing other entities that provide legal abortions to receive Medicaid reimbursements for other services, constitutes punishment within the meaning of the Bill of Attainder Clause regardless of whether abortion itself is constitutionally protected.

Defendants next assert that Section 71113 furthers a non-punitive end where "Congress could reasonably conclude that withholding Medicaid funding from entities that perform abortions will discourage at least some . . . abortions." Mem. ISO Mot. to Stay 5–6 [Doc. No. 85]. But Defendants acknowledgement that Section 71113 ends Medicaid funding only "for certain abortion providers," Mem. ISO Mot. to Stay 3 [Doc. No. 85], undercuts their contention that the law is nonpunitive. Indeed, the court determined that "there is a poor fit between Section 71113" and the goal of reducing abortion where the law "excludes few abortion providers from participating in Medicaid programs and bars Planned Parenthood Members that do not provide

abortion from receiving Medicaid funds." Mem. & Order 38–39 [Doc. No. 69]; cf. id. at 47 (explaining "Plaintiffs are likely to show that there is no rational relationship between the class burdened by Section 71113 . . . and the goal of reducing abortion" where "Section 71113 affects only a small number of abortion providers and leaves every other conceivable category unaffected.").

Further, the law's inclusion of only "certain abortion providers" supports the conclusion that Congress acted with an intent to punish. "Courts conduct [the] inquiry" into legislative intent "by reference to legislative history, the context or timing of the legislation, or specific aspects of the text or structure of the disputed legislation." Foretich v. U.S., 351 F.3d 1198, 1225 (D.C. Cir. 2003) (citing Selective Serv. Sys., 468 U.S. at 855 n.15). Here, Section 71113's text and structure, namely the conjunctive criteria that capture "every Planned Parenthood Member and exclude all but two other Medicaid providers[,]" substantiate the conclusion that Congress intended to punish Planned Parenthood Federation and its Members. Mem. & Order 40 [Doc. No. 69].

Additionally, although "statements by individual legislators rank among the least illuminating forms of legislative history" when determining what Congress intended a statute to mean, NLRB v. SW Gen., Inc., 580 U.S. 288, 307 (2017), statements by individual legislators in bill-of-attainder cases are relevant "where the very nature of the constitutional question requires an inquiry into legislative purpose[,]" i.e. whether Congress intended to single out a particular group for punishment. See United States v. O'Brien, 391 U.S. 367, 384 n.30 (1968). And here, where Section 71113's text does, in fact, single out Planned Parenthood Members, the legislative backdrop and statements in the record only corroborate that this was Congress's intent. See Mem. & Order 40–41 [Doc. No. 69].

Relatedly, Section 71113 satisfies the specification prong. A bill of attainder must name the affected parties or apply "to easily ascertainable members of a group[.]" United States v. Lovett, 328 U.S. 303, 315 (1946). A law satisfies the specification prong where it defines the affected class "entirely by irreversible acts committed by them" in the past. See Selective Serv. Sys., 468 U.S. at 848. Courts "have established [four] guideposts to aid in determining whether legislation singles out a person or class within the meaning of the Bill of Attainder Clause." SeaRiver Mar. Fin. Holdings, Inc. v. Mineta, 309 F.3d 662, 669 (9th Cir. 2002) (citing Selective Serv. Sys., 468 U.S. at 847, United States v. Brown, 381 U.S. 437, 448–49 (1965), and circuit court decisions). Here, the court determined that Plaintiffs were likely to succeed in establishing that Planned Parenthood Federation and its Members were the easily ascertainable target of Section 71113 based on three of these guideposts—whether the identity of the affected class was easily ascertainable when the law was passed, whether the class was defined by "past conduct [that] operates only as a designation of particular persons," and whether "the past conduct defining the affected individual or group consists of 'irrevocable acts committed by them." Mem. & Order 32–36 [Doc. No. 69].

Defendants cite Communist Party of the United States v. Subversive Activities Control Board, 367 U.S. 1 (1961), to argue that "because Section 71113 turns on whether an entity meets various requirements 'as of' [October 1, 2025]" and "plaintiffs 'can escape regulation' by altering their activities," Section 71113 does not define prohibited entities based on "'past conduct,' and instead focuses on future activity." Mem. ISO Mot to Stay 7 [Doc. No. 85]. But Defendants ignore that Section 71113 singles out Planned Parenthood Members by defining the class subject to the regulation based on immutable facts: Only entities that are "essential community provider[s] . . . primarily engaged in family planning services, reproductive health,

and related medical care" who, during fiscal year 2023 received more than $800,000 in Medicaid reimbursements or were affiliated with such an entity, are subject to the restriction that the entity not provide abortions as of October 1, 2025. Pub. L. No. 119-21, § 71113(b)(1) 139 Stat. 72 (2025).

For this reason, Section 71113 is distinct from the law at issue in Communist Party. There, any organization could be subject to the law's burden if they engaged in activities triggering the requirement, and each such organization could then shed that burden, if it "should at any time choose to abandon these activities." 367 U.S. at 87. Here, Section 71113 uses retrospective characteristics—including that, in 2023, the entity received at least $800,000 in Medicaid reimbursements or affiliated with an entity that received that amount—to identify the limited set of entities (Planned Parenthood Members and two others) who are burdened with the regulation in the first place. Further, Planned Parenthood Members cannot avoid Section 71113 by abandoning activities at any time; so long as a Member provides elective abortion as of October 1 or affiliates with an entity that does so, it is barred by Section 71113 from receiving Medicaid reimbursements for any services rendered during the entire period that the law is effective. Therefore, the law's burden does not "endure only so long as[] an organization presently conducts operations of a described character." Id.

In any event, Defendants do not dispute that historically, "some [bills of attainder] left the designated parties a way of escaping the penalty." United States v. Brown, 381 U.S. 437, 442 (1965). Consequently, Defendants' reliance on Communist Party is insufficient to make the requisite showing that they are likely to prevail on the merits of Plaintiffs' bill of attainder claim.

B. *The Remaining Stay Factors*

Defendants have not carried their burden to establish that the remaining factors support staying preliminary relief.

Defendants assert that preliminary injunctive relief threatens significant irreparable harm to the government by interfering with Congress's power over federal spending and the "Executive Branch's authority and ability to enforce the law[.]" Mem. ISO Mot to Stay 15 [Doc. No. 85]. But Defendants do not dispute the court's conclusion that Section 71113 has a negligible impact on the federal budget or on Medicaid spending. See Mem. & Order 53 [Doc. No. 69]. Instead, Defendants point out that "Congress adjusts federal spending for many reasons other than reducing the overall budget deficit[,]" and assert that Congress has determined that "halting funding to certain large abortion providers serves the public interest." Mem. ISO Mot. to Stay 16 [Doc. No. 85].

But "Congress exercises its conferred powers subject to the limitations contained in the Constitution." New York v. United States, 505 U.S. 144, 156 (1992). Therefore, "other constitutional provisions may provide an independent bar" to Congress's exercise of its spending power. South Dakota v. Dole, 483 U.S. 203, 208 (1987). Here, Defendants suffer no irreparable harm where Plaintiffs are substantially likely to succeed in establishing that Section 71113 violates several constitutional provisions. As explained above and in the court's previous orders, it is precisely because Congress targeted only a "certain" group of entities for exclusion from Medicaid programs—all but two of which are Planned Parenthood Federation Members—that Plaintiffs are likely to succeed in establishing that Section 71113 is unconstitutional. See generally Mem. & Order 30–49 [Doc. No. 69]. Although Congress has significant latitude in allocating funds "from a finite pool of resources," Congress cannot pursue fiscal objectives "by

discriminating against individuals or groups." See Lyng v. Int'l Union, United Auto., Aerospace & Agr. Implement Workers of Am., UAW, 485 U.S. 360, 373 (1988). Where Plaintiffs have shown that Congress has likely exercised its power in violation of Plaintiffs and Planned Parenthood Federation Members' constitutional rights, Defendants do not suffer irreparable harm from preliminary relief pending a final determination of Plaintiffs' claims. Cf. Somerville Pub. Sch. v. McMahon, 139 F.4th 63, 74–75 (1st Cir. 2025) (concluding preliminary injunction "undermining implementation" of federal policy would not cause government irreparable injury where government conceded that policy would be unlawful).

Moreover, Defendants have not established that a stay should issue where Plaintiffs and Planned Parenthood Federation Members face irreparable harm in the absence of preliminary injunctive relief. Although Defendants disagree with the court's conclusions regarding Plaintiffs' constitutional claims, see Mem. ISO Mot for Stay 16 [Doc. No. 85], they do not dispute the principle that constitutional harms, and impingement on First Amendment Freedoms in particular, is an irreparable injury. See Mahmoud v. Taylor, 606 U.S. __, 145 S. Ct. 2332, 2364 (2025). And staying relief that preliminarily enjoins Section 71113's enforcement is counter to the public interest where Plaintiffs are likely to succeed in establishing that Section 71113 is unconstitutional. See Somerville Pub. Sch. v. McMahon, 139 F.4th 63, 76 (1st Cir. 2025); New Hampshire Indonesian Cmty. Support v. Trump, 765 F. Supp. 3d 102, 112 (D.N.H. 2025) (explaining government has "no interest in enforcing an unconstitutional law, [and] the public interest is harmed by the enforcement of laws repugnant to the United States Constitution[]") (citation omitted) (alteration in original); see also Mem. & Order 54 [Doc. No. 69] (citing Roman Cath. Diocese of Brooklyn, 592 U.S. 14, 19–20 (2020)).

Moreover, Plaintiffs have shown via declaration that Planned Parenthood Member clinics will be forced to reduce or eliminate healthcare services and turn away Medicaid patients, that some Member clinics are likely to temporarily or permanently close, and that all Planned Parenthood Member patients are likely to face increased wait times and disrupted or reduced access to care. See Custer Decl. ¶¶ 4, 51, 54–57, 78 [Doc. No. 5-1]; Lee Decl. ¶¶ 40–42 [Doc. No. 5-2]; Ghorbani Decl. ¶¶ 6, 24 [Doc. No. 5-3]; Tosh Decl. ¶¶ 45–48 [Doc. No. 5-4]. In light of this showing, Defendants' unsupported suggestions that Plaintiffs could continue providing the same level of service with other funding sources and that Medicaid patients could obtain the same care from other healthcare providers, see Mem. ISO Mot. to Stay 16 [Doc. No. 85], do not establish that a stay is otherwise in the public interest.

Defendants ultimately contend that because Acts of Congress are presumptively constitutional, they "'should remain in effect pending a final decision on the merits' by the Supreme Court." Mem. ISO Mot. to Stay 2, 15 [Doc. No. 85] (quoting Turner Broadcasting System, Inc. v. FCC, 507 U.S. 1301, 1302 (1993) (Rehnquist, C.J., in chambers)). But here, the court has determined that Plaintiffs have rebutted the presumption of constitutionality that attaches to Acts of Congress for the purpose of seeking preliminary relief. See, e.g., Mem. & Order 54 [Doc. No. 69] (explaining preliminary injunction is in public interest "[w]here Plaintiffs have demonstrated a substantial likelihood of success on constitutional claims premised on impingement of First Amendment associational rights, singling out Planned Parenthood Federation and its Members for legislative punishment, and denial of equal protection").

Courts "may not resolve a conflict between considered review and effective relief" by granting a stay "reflexively." See Nken v. Holder, 556 U.S. 418, 427 (2009). Although the

issuance of a stay is left to the court's discretion, that "does not mean that no legal standard governs that discretion . . . . [A] motion to [a court's] discretion is a motion . . . to its judgment; and its judgment is to be guided by sound legal principles." Id. at 434 (internal citation and quotations omitted). Those legal principles have been distilled into the four stay factors. Id. And for the reasons explained above, Defendants have not established that any of those factors weigh in favor of a stay.

IV. Conclusion

For the foregoing reasons, Defendants' Motion to Stay Preliminary Injunctions Pending Appeal [Doc. No. 84] is DENIED.

IT IS SO ORDERED.

August 29, 2025

/s/Indira Talwani
United States District Judge

CERTIFICATE OF SERVICE

I hereby certify that on September 29, 2025, I electronically filed the foregoing appendix with the Clerk of the Court for the United States Court of Appeals for the First Circuit by using the appellate CM/ECF system. Service will be accomplished by the appellate CM/ECF system.

s/ Steven H. Hazel
Steven H. Hazel