Case No. 18-1514

UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

COMMONWEALTH OF MASSACHUSETTS,

Plaintiff-Appellant,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,

Defendants-Appellees.

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

BRIEF OF THE *AMICI CURIAE* PUBLIC HEALTH SCHOLARS IN SUPPORT OF PLAINTIFF-APPELLANT THE COMMONWEALTH OF MASSACHUSETTS SEEKING REVERSAL OF THE DECISION BELOW

Christopher Escobedo Hart (1st Cir. Bar No. 1153981; BBO# 625031)
Emily J. Nash (BBO# 696460)
FOLEY HOAG LLP
155 Seaport Boulevard
Boston, MA 02210
Telephone: (617) 832-1232
Email: chart@foleyhoag.com

Attorneys for Amici Curiae Public Health Scholars

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STATEMENT OF INTEREST OF *AMICI CURIAE*[1]

Amici curiae are twenty-one researchers and academics who are experts in the fields of women's health, health law, health policy, health services research, and national health reform. They seek to inform the Court about the direct injury the Commonwealth of Massachusetts will suffer if the Interim Final Rules put forth by the Departments of Health and Human Services, Treasury, and Labor are put into effect.

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[1] In accordance with Fed. R. App. P. 29, all parties have consented to the filing of this amicus brief. Counsel for *amici* state that this brief was not authored, in whole or in part, by counsel to a party, and no monetary contribution to the preparation or submission of this brief was made by any person or entity other than *amici* or their counsel. *Amici* are identified individually in Appendix A.

SUMMARY OF THE ARGUMENT

The Commonwealth of Massachusetts (the "Commonwealth") will suffer direct and quantifiable harm if the two Interim Final Rules ("IFRs") issued by the United States Departments of Health and Human Services ("HHS"), Treasury and Labor on October 13, 2017 are permitted to go into effect. The IFRs authorize employers to refuse to offer their employees health insurance coverage of contraceptive services currently guaranteed by the Patient Protection and Affordable Care Act ("ACA"), by allowing employers to take advantage of either an expansion to the ACA's religious exemption, or of a new "moral convictions" exemption (the "Moral Exemption Rule").[2]

The Commonwealth brought this action against the three federal agencies and their Secretaries ("Defendants") seeking to enjoin enforcement of the IFRs. The U.S. District Court for the District of Massachusetts concluded that the Commonwealth lacked standing to pursue its claims, reasoning that Massachusetts could not "demonstrate that an actual injury to its economic or quasi-sovereign interests is likely to occur."[3]

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[2] 82 Fed. Reg. 47,799 ("Religious Exemption Rule") (Joint Appendix ("JA") 836-78); 82 Fed. Reg. 47,838 (JA 880-904).

[3] *Massachusetts v. U.S. HHS*, No. 17-cv-11930-NMG, 2018 U.S. Dist. LEXIS 40030, at *41 (Mar. 12, 2018) (JA 1421).

Contrary to the lower court's ruling, the Commonwealth will in fact experience a direct injury if the IFRs are implemented because its residents will lose access to the coverage for contraceptive services to which they are currently entitled under the ACA. Setting aside the harm that would befall the Commonwealth's residents (especially its female residents), the Commonwealth itself would incur significant costs if the IFRs are permitted to take effect—costs that the ACA alone neither imposes nor contemplates. As this brief demonstrates, many Massachusetts women whose employers take advantage of these exemptions will turn to state-funded healthcare options either for contraceptives or for care resulting from unintended pregnancies. For each woman who does, the Commonwealth will shoulder additional costs. Contrary to the lower court's conclusions, these "substantial fiscal burdens on [s]tate coffers" suffice to establish injury in fact and, thus, Article III standing.[4]

ARGUMENT

I. LEGAL STANDARD.

The Commonwealth can establish an injury in fact sufficient for Article III standing by demonstrating that there is a "substantial risk that the [threatened] harm

[4] *Pennsylvania v. Trump*, 281 F. Supp. 3d 553, 567 (E.D. Pa. 2017); *see California v. HHS*, 281 F. Supp. 3d 806, 822 (N.D. Cal. 2017).

will occur."[5] This Court has explained that "whether a risk is speculative also depends on the chances that the risked harm will occur."[6] Notably, however, "even a small probability of injury is sufficient to create a case or controversy—to take a suit out of the hypothetical."[7]

Injury in fact may be demonstrated through patterns of behavior and "sequence[s] of economic events."[8] Basic economic principles may be applied to determine the likelihood of future fiscal harm.[9] For example, "competitor standing" may be found where plaintiffs demonstrate a sufficient likelihood that a government action will harm them competitively.[10] In such cases, the requisite "substantial risk" of future injury is shown through a chain of economic events that demonstrates the

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[5] *Susan B. Anthony List v. Driehaus*, 134 S. Ct. 2334, 2341 (2014) (quoting *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 414 n.5 (2013)); *see Reddy v. Foster*, 845 F.3d 493, 497 (1st Cir. 2017).

[6] *Kerin v. Titeflex Corp.*, 770 F.3 978, 983 (1st Cir. 2014).

[7] *Massachusetts v. EPA*, 549 U.S. 497, 525 n.23 (2007) (quoting *Village of Elk Grove Village v. Evans*, 997 F.2d 328, 329 (7th Cir. 1993)).

[8] *Adams v. Watson*, 10 F.3d 915, 922 (1st Cir. 1993); *see Monsanto Co. v. Geertson Seed Farms*, 561 U.S. 139, 153-54 (2010) (acknowledging the "substantial risk of gene flow" to conventional alfalfa crops would injure the plaintiffs through the increase in costs they would incur to test their seeds and find new growers); *cf. Susan B. Anthony List*, 134 S. Ct. at 2345 (noting history of past enforcement as demonstrating threat of future enforcement); *Massachusetts*, 549 U.S. at 521-22 (holding that Massachusetts demonstrated injury-in-fact, citing past harms of climate change to demonstrate likelihood of future harm).

[9] *See Adams*, 10 F.3d at 923 (1st Cir. 1993).

[10] *Id.* at 920-22.

probability of fiscal harm.[11] The future harm here can similarly be demonstrated through economic principles and market behavior.

The Commonwealth need not demonstrate that the economic harm it expects to suffer meets any threshold amount to constitute injury-in-fact for Article III standing. As this Court has explained, "[i]t is a bedrock proposition that 'a relatively small economic loss—even an 'identifiable trifle'—is enough to confer standing."[12] By analyzing data demonstrating market participation and use of contraceptives, on the one hand, alongside the Commonwealth's insurance and community health structures, on the other, it is apparent that there is a substantial risk of economic injury to the Commonwealth. "[T]he Commonwealth need not sit idly by and wait for fiscal harm to befall it."[13]

The Commonwealth has already adequately demonstrated the injury it will likely suffer should the IFRs go into effect. As framed by the court below, the Commonwealth presented three theories of injury to support its standing to sue: (1) "an injury to the state fisc," (2) "an injury to the health and well-being of its residents," and (3) "a procedural injury under the APA."[14] *Amici* focus here only on

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[11] *Id.* at 922.
[12] *Katz v. Pershing, LLC*, 672 F.3d 64, 76 (1st Cir. 2012) (quoting *Adams*, 10 F.3d at 924).
[13] *Pennsylvania*, 281 F. Supp. 3d at 567.
[14] JA 1402.

the first theory, demonstrating the negative impact that the IFRs would have on the Commonwealth's treasury because of the costs Massachusetts would incur to provide contraceptive or other healthcare services to women whose employers take advantage of the new exemptions.[15] Viewing the healthcare coverage landscape more broadly—considering both where women turn for contraceptive coverage when it is not provided by employer-funded plans, as well as the specific healthcare structures present in Massachusetts—reveals the direct fiscal harm the Commonwealth will suffer should the IFRs go into effect.

II. CONTRACEPTIVE COVERAGE IS AN ESSENTIAL COMPONENT OF PREVENTIVE HEALTHCARE FOR AMERICAN WOMEN.

A. The Availability of Contraceptive Coverage is Crucial to Public Health.

Contraception offers women greater control over their reproductive behaviors, fertility and childbearing. A typical American woman, who may want two children, must avoid unintended pregnancy for about three decades—that is, during most of her reproductive years.[16] In *Planned Parenthood v. Casey*, the Supreme Court acknowledged that "[t]he ability of women to participate equally in the economic

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[15] *Amici* agree that there are also other harms, but refer the Court to the Commonwealth's brief and the briefs of other *amici* regarding those arguments.

[16] Sonfield, A., et al., *Moving Forward: Family Planning in the Era of Health Reform*, Guttmacher Inst. (2014), http://www.guttmacher.org/sites/default/files/report_pdf/family-planning-and-health-reform.pdf. This study, and all studies contained herein, are publicly available documents.

and social life of the Nation has been facilitated by their ability to control their reproductive lives."[17] Access to contraceptives has allowed women to pursue advanced educational and career opportunities: It is credited with one-third of the increase in women's college enrollment in the 1970s[18] and a 30% increase in the proportion of women in skilled careers.[19] Sexually active American women today have the opportunity to choose among reliable options for contraception, and women in fact take advantage of this opportunity by the millions, regardless of religious affiliation or professional occupation.[20]

The efficacy of contraception in preventing unintended pregnancies is beyond dispute. The Centers for Disease Control and Prevention ("CDC") advise that, aside from permanent sterilization, long-acting reversible contraceptive methods ("LARCs") such as intrauterine devices ("IUDs") or hormonal implants are the most effective methods for preventing pregnancy, followed by medical methods such as oral contraceptives or injectable contraceptives.[21] One prominent study examining

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[17] *Planned Parenthood v. Casey*, 505 U.S. 833, 856 (1992).
[18] Hock, H., *The Pill and the College Attainment of American Women and Men*, Florida St. U. (2007); Ananat, E. & Hungerman, D., *The Power of the Pill for the Next Generation: Oral Contraception's Effects on Fertility, Abortion, and Maternal and Child Characteristics*, 94 Rev. of Econ. and Stat. 37 (2012).
[19] Goldin C. & Katz L., *The Power of the Pill: Oral Contraceptives and Women's Career and Marriage Decisions*, 110 J. of Pol. Econ. 730 (2002).
[20] Sonfield, *Moving Forward*, *supra*, at 3.
[21] *See* Ctrs. for Disease Control and Prevention, *Effectiveness of Family Planning Methods* (2011),

the cost-effectiveness of contraceptive methods noted that while LARCs are the most cost-effective over a five-year time horizon, any contraceptive method is superior to no contraception for preventing unintended pregnancies.[22]

The CDC—notably, an agency within Defendant HHS—cited the development of and improvements in contraception as one of the greatest public health achievements of the twentieth century.[23] Indeed, HHS underscored the public health significance of contraception by including such services in the "Healthy People 2020 Framework," the agency's official public health objectives for improving Americans' health (published once every decade).[24] Three key goals related to contraception include: (1) "[i]ncreas[ing] the proportion of pregnancies that are intended," (2) "[i]ncreas[ing] the proportion of health insurance plans that cover contraceptive supplies and services," and (3) increasing contraceptive use among "the proportion of females at risk of unintended pregnancy" and their

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http://www.cdc.gov/reproductivehealth/contraception/unintendedpregnancy/pdf/Contraceptive_methods_508.pdf.

[22] Trussell, J., et al., *Cost Effectiveness of Contraceptives in the United States*, 79 Contraception 5 (2009).

[23] Ctrs. for Disease Control and Prevention, *Achievements in Public Health, 1900-1999: Family Planning*, Morbidity and Mortality Weekly Rep. (Dec. 3, 1999), http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4847a1.htm.

[24] Dep't of Health & Human Servs., *Healthy People 2020 Framework*, http://www.healthypeople.gov/sites/default/files/HP2020Framework.pdf.

partners.[25] Similarly, the Commonwealth has also stated that reducing the number of unplanned pregnancies is an important public health goal.[26] The Commonwealth's emphasis on contraceptive equity is also evident in its legislative action from the past two decades.[27] Both the federal government and the Commonwealth, therefore, have a strong interest in promoting the availability of contraceptive services.

B. The Current Framework for Contraceptive Coverage Advances Public Policy.

Academic studies and state and local policymaking demonstrate that there are significant public health benefits in requiring private insurers to cover preventive health services. The ACA notes that such services must be covered at no cost to individuals who are insured through non-grandfathered employer-sponsored health

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[25] Dep't of Health & Human Servs., *Family Planning*, HealthyPeople.gov (Updated Sept. 21, 2018), http://www.healthypeople.gov/2020/topics-objectives/topic/family-planning/objectives. Notably, the published objective to "increase the proportion of health insurance plans that cover contraceptive supplies and services" was "archived" in 2014 because of the Guttmacher Institute's determination that conducting further studies of health insurance plan coverage would no longer be necessary after the ACA's contraceptive mandate went into effect. *See* Dep't of Health & Human Servs., *FP-4 Data Details*, HealthyPeople.gov, http://www.healthypeople.gov/node/4460/data_details#revision_history_header.

[26] Kotelchuck, M., *Policy Perspective: Reproductive and Infant Health*, Health of Mass., at 74 (Apr. 2010), http://www.mass.gov/files/2017-08/health-mass.pdf.

[27] *See* Mass. St. 2002, c. 49 ("Contraceptive Equity Law"); Mass. St. 2017, c. 120 ("ACCESS Act").

plans that do not qualify for a narrow church exemption.[28] To this end, the ACA provision known as the Women's Health Amendment tasked the Health Resources and Services Administration ("HRSA"), a branch of HHS, with defining which preventive services "with respect to women" fall within the ACA's ambit.[29] To do so, the HRSA relied on evidence and recommendations presented by the Institute of Medicine[30] and concluded that the ACA's preventive services should include, "without cost sharing," "[a]ll Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity."[31] In short, the HRSA determined, based on significant data, that the ACA's goals regarding preventive services would be best served by covering *all* contraceptive services, without any cost-sharing.

Mandates are effective in changing outcomes and achieving public health goals, and they have proven effective for contraceptive services specifically. Before

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[28] Ctrs. for Medicare & Medicaid Servs., *Background: The Affordable Care Act's New Rules on Preventive Care*, Ctr. for Consumer Info. & Ins. Oversight (July 14, 2010), http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/preventive-care-background.html; *see* 42 U.S.C. §§ 18022, 300gg-13.

[29] 42 U.S.C. § 300gg-13(a)(4).

[30] Inst. of Med., *Clinical Preventive Services for Women: Closing the Gaps* (2011) (JA 125-373). The Institute of Medicine is now known as the Health and Medical Division of the National Academies of Sciences, Engineering, and Medicine. *See* Nat'l Acads. of Sciences, Engineering, & Med., *About Us* (Jan. 16, 2018 4:13PM), http://www.nationalacademies.org/hmd/About-HMD.aspx.

[31] Health Res. & Servs. Admin., *Women's Preventive Services Guidelines* (Oct. 2017), http://www.hrsa.gov/womens-guidelines/index.html (JA 1343-47).

the ACA mandate went into effect, more than half of states required private insurers to cover contraceptive drugs and devices.[32] Privately-insured women living in states with such a mandate were 64% more likely to use a contraceptive method consistently during sexual encounters than women living in states without such a mandate, even after accounting for differences such as education or income.[33]

Cost-sharing is also an effective framework implemented by the ACA because the costs of contraceptive methods, particularly the most effective LARCs (like IUDs or hormonal implants), can create a financial barrier for most people. For example, one study estimated that the initial cost of an IUD includes $598 for an IUD device and $278 for physician services (*i.e.* the initial consultation, insertion, and follow-up); this is far more expensive than the $370 for 12 months of oral contraceptives and $42 for physician services to prescribe them.[34] Although the initial cost of an IUD is roughly twice as high as other methods, it lasts for a longer period and is more effective in preventing pregnancy.[35] By contrast, the barrier to purchasing the pill is far lower upfront, but it requires regular, continual payments for monthly packets and daily adherence, without disruption, by female patients.

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[32] Magnusson, B.M., et al., *Contraceptive Insurance Mandates and Consistent Contraceptive Use Among Privately Insured Women*, 50 Med. Care 562 (July 2012).
[33] *Id.*
[34] Trussell, J., et al., *Achieving Cost-Neutrality with Long-acting Reversible Contraceptive Methods*, Contraception 49 (2015).
[35] *See* CDC, *Effectiveness*, *supra*.

Data shows that eliminating cost-sharing structures such as deductibles and copayments for contraception fosters greater use of more effective contraceptive methods, reducing pregnancy and birth rates.[36] For example, a demonstration project in Colorado tested elimination of cost-sharing for LARCs by providing private funding to Title X clinics in the state to support the provision of LARC methods to young women.[37] Over the course of two years, LARC usage increased from 5% of this group to 19%, while fertility rates dropped by 29% for low-income women age 15-19 and by 14% for similar 20-24-year-olds.[38] Between 2010 and 2013, the proportion of births deemed to be high-risk declined by 24%, and infant enrollment in a Colorado welfare program declined 23%.[39] Similarly, a Missouri demonstration project focused on preventing unintended pregnancies made LARC methods available without cost.[40] As a result, 75% of women studied chose a LARC method, and the teenage birth rate dropped to 6 per 1,000 females, compared with a

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[36] *See, e.g.*, Postlethwaite, D., et al., *A Comparison of Contraceptive Procurement Pre- and Post-Benefits Change*, 76 Contraception 360 (2007) (JA 382-87); Peipert, J.F., et al., *Preventing Unintended Pregnancy by Providing No Cost Contraception*, 120 Obstetrics & Gynecology 1291 (2012) (JA 480-87); Ricketts, S., et al., *Game Change in Colorado: Widespread Use of Long-Acting Reversible Contraceptives and Rapid Decline in Births Among Young, Low-Income Women*, 46 Persp. on Sexual & Reprod. Health 125 (2014).
[37] Ricketts, *supra*.
[38] *Id.*
[39] *Id.*
[40] JA 480-87.

national average of 34 per 1,000.[41] The study focused on teenage birth "as a proxy for unintended pregnancy because up to 80% of these births are unintended."[42]

Following the passage of the ACA, there were substantial reductions in how much women were required to spend for their contraceptives, lowering their average annual copayments for oral contraceptives and IUDs by about $250 per year.[43] As a result, from 2009 (before the ACA) to 2016, the percentage of "family planning users" at Title X family planning clinics who were uninsured fell from 66% to 43%, and the percentage with private insurance rose from 8% to 18%.[44] The growth in insurance coverage made use of the most effective forms of contraception, such as IUDs and hormonal implants, more affordable and accessible; the share of female clients using the most effective forms of contraception thus rose from 7% in 2009 to 17% in 2016.[45] The percentage of teenaged females who reported that they did not use a contraceptive the last time they had sex fell from 17% in 2002 to 10% in 2011-

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[41] *Id.*
[42] JA 483.
[43] Becker, N.V. & Polsky, D., *Women Saw Large Decreases on Out-of-Pocket Spending for Contraceptives After the ACA Mandate Removed Cost-Sharing*, 34 Health Aff. 1204 (2015).
[44] Off. of Population Aff., Dept. of Health & Human Servs., *Title X Family Planning Annual Report*, 2016 Nat'l Summary, at A-18-19 (Aug. 2017), http://www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf.
[45] *Id.* at A-9b.

15.[46] According to a recent survey, 80% of women reported that eliminating cost-sharing helped them afford and use contraception, and 60% said that its elimination helped them choose a better method of contraception.[47] Thus, even though the ACA has only been in effect for a short time, data illustrates that it has already led to substantial advances toward its preventive health aims.

III. THE IFRS WOULD DIRECTLY INJURE THE COMMONWEALTH.

A. The Moral Exemption Rule Creates a Direct Injury to the Commonwealth's Treasury.

There should be no doubt that some share of female Massachusetts residents will be affected by the IFRs. Defendants estimate in the Religious Exemption Rule that that between 31,700 and 120,000 women who are currently using "affected contraceptives" could lose their employer-sponsored coverage.[48] Census data indicate that about 2.3% (878,000) of U.S. women of childbearing age (ages 15 to 44) with employer-sponsored health insurance coverage live in Massachusetts.[49]

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[46] Abma, J. & Martinez, G., *Sexual Activity and Contraceptive Use Among Teenagers in the United States, 2011-2015*, 104 Nat'l Health Stat. Rep. (June 22, 2017), http://www.cdc.gov/nchs/data/nhsr/nhsr104.pdf.

[47] Bearak, J.M. & Jones, R.K., *Did Contraceptive Use Patterns Change After the Affordable Care Act? A Descriptive Analysis*, 27 *Women's Health Issues* 316 (2017).

[48] JA 865-67.

[49] Appendix B, U.S. Census Bureau, *Current Population Survey (CPS): CPS Table Creator*, http://www.census.gov/cps/data/cpstablecreator.html ("App. B"). To assist the Court, this Appendix is a version of a table created using a publicly-available website published by the U.S. Census Bureau and available on its website, demonstrating women age 15 to 44 covered by employment-based health insurance

Thus, even accepting Defendants' figures regarding the estimated range of women who will lose contraceptive coverage nationwide, this leaves between 729 and 2,760 women in this position in the Commonwealth.

In fact, the actual number of affected women will likely be far greater than Defendants' estimates. First, the Moral Exemption Rule is a regulatory innovation without precedent in the healthcare arena, let alone the ACA itself, leaving scholars and legislators alike speculating on its potential impact. Still, calculations of impact are possible, and such calculations demonstrate that the Moral Exemption Rule has the potential to affect thousands of women in the Commonwealth. For example, a 2016 national poll found that 4% of American adults believe that contraception is "morally wrong," with 36% reporting it as morally acceptable and 57% stating that it was not a moral issue at all.[50] If 4% of employers in Massachusetts were willing to claim a "moral exemption" to the contraceptive mandate, and 4% of the 878,000 Massachusetts women 15 to 44 years old who have employer-sponsored insurance[51]

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nationwide and separated by state. All notations on the document were made by *amicus* Professor Leighton Ku.

[50] Pew Res. Ctr., *Very Few Americans View Contraception as Morally Wrong*, Where the Public Stands on Liberty vs. Nondiscrimination (Sep. 28, 2016), http://www.pewforum.org/2016/09/28/4-very-few-americans-see-contraception-as-morally-wrong.

[51] *See* App. B at 4.

are denied contraceptive coverage, then 35,100 would lose this contraceptive coverage.

Second, Defendants' figures underestimate the number of affected women because they represent only a point-in-time estimate. The number of affected people will grow over time, as more and more female patients enter or re-enter the market for contraceptive care to obtain directly through the market what they can no longer receive through their employers.

To understand why, it is important to consider that when a woman loses insurance-based contraceptive coverage, she is left with three basic options: (1) purchase contraceptives out of her own pocket, without insurance; (2) find another way to obtain free or reduced-price contraception; or (3) risk unintended pregnancies by either foregoing contraception altogether or relying on cheaper, less effective methods, such as condoms. The choice is starker for low-income women who are unable to afford contraceptive services on her own. The IFRs estimate the cost of contraceptive services at $584 per year, a substantial amount for a low-income woman or family.[52] For a woman living in a family earning twice the federal poverty level ($32,920 for a family of two), for example, this new contraceptive coverage expense would represent 2.1% of the family's average take-home pay after taxes, or

[52] JA 865.

the equivalent of an entire week's take-home pay.[53] If she cannot afford to use contraception on a regular basis throughout the year, her risk of unintended pregnancy rises greatly.[54] As noted above, long-acting reversible contraceptives are the most effective forms of contraception, but they are even more expensive upfront, costing roughly twice as much as less effective methods, and therefore even less accessible for young and low-income women without insurance coverage.[55]

The Commonwealth itself incurs substantial costs—experiencing direct fiscal injury—to provide the additional healthcare services to pick up the pieces when contraceptive coverage is no longer provided to these women through their employers. This direct economic harm to Massachusetts occurs when (1) the Commonwealth must spend more to provide contraceptive services because they are no longer available through employer-sponsored coverage, and (2) when a woman has an unintended pregnancy or birth, resulting in substantially higher medical and social costs to the Commonwealth, as well as to the woman, her family, and her community. Although the exact number of women who may lose employer-

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[53] *See* ADP, *Salary Paycheck Calculator*, http://www.adp.com/tools-and-resources/calculators-and-tools/payroll-calculators/salary-paycheck-calculator.aspx (using standard federal and Massachusetts taxes for 2018).
[54] *See* CDC, *Effectiveness*, *supra*.
[55] Eisenberg, D., et al., *Cost as a Barrier to Long-Acting Reversible Contraceptive (LARC) Use in Adolescents*, 52 *Journal of Adolescent Health* S59 (Apr. 2013); Trussell, *Achieving Cost-Neutrality*, *supra*.

sponsored contraceptive coverage is uncertain, the costs the Commonwealth would incur if even one woman eligible for state-sponsored services were to lose coverage are ascertainable, as explained below.

B. The Commonwealth Would Be Directly Harmed Due to Increased Expenses It Would Incur to Provide Contraceptive Coverage Through Medicaid or Other Safety Net Programs.

As women lose employer-sponsored contraceptive coverage, they will seek that coverage through other insurance structures, each of which implicate the Commonwealth's treasury. Indeed, these fallback plans were contemplated by Defendants when issuing the IFRs, explaining that women may turn to "multiple Federal, State, and local programs that provide free or subsidized contraceptives for low-income women" if and when their employers claim the new exemptions.[56]

1. MassHealth.

For low-income women who lose private coverage for contraceptives due to the IFR exemptions, Medicaid can act as an important safeguard. This safeguard, however, shifts costs from private employers to the government. Medicaid expenses are borne by states and the federal government.[57] Under the Social Security Act, all state Medicaid plans must cover family planning services (including examination, counseling, contraceptives and related health care services).[58] States are responsible

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[56] JA 857, 892.
[57] 42 U.S.C. § 1396(b).
[58] 42 U.S.C. § 1396d(a)(4).

for 10% of Medicaid's "family planning" expenses.[59] Medicaid also acts as a secondary payer for people who qualify for medical assistance but also have other insurance coverage through an employer plan.[60] In such cases, Medicaid becomes the secondary payer for covered services not offered through their employer plans.[61] Dually covered women do not need to specially apply for contraceptive coverage; if their private insurance plan denies the coverage, Medicaid automatically pays for contraceptive services as a secondary payer.[62]

Massachusetts, like the majority of U.S. states, has chosen to expand Medicaid coverage, resulting in some additional cost to the state.[63] MassHealth,

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[59] 42 U.S.C. § 1396b(a)(5).
[60] 42 U.S.C. § 1396e.
[61] Ctrs. for Medicare & Medicaid Servs., *Medicaid Third Party Liability & Coordination of Benefits*, http://www.medicaid.gov/medicaid/eligibility/tpl-cob/index.html.
[62] *See* 42 U.S.C. § 1396e.
[63] Holahan, J., et al., *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, Kaiser Commission on Medicaid and the Uninsured (Nov. 2012), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384.pdf. At the time of drafting, 31 states and the District of Columbia have also expanded adults' Medicaid eligibility to at least 138% of poverty (Virginia plans to expand Medicaid but has not done so yet, and Maine passed a referendum to expand eligibility, but its governor has refused to comply). Kaiser Family Found., *Status of State Action on the Medicaid Expansion Decision* (Sep. 11, 2018), http://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Massachusetts' Medicaid program, provides coverage for adults ages 19 to 64 with incomes up to 138% of the federal poverty line and for children ages 6 to 18 with incomes up to 155% of the poverty line.[64] If a woman who falls into one of these categories loses her employer-sponsored contraceptive coverage as a result of the IFRs, but participates in MassHealth, she can receive contraceptive coverage through MassHealth.[65] Massachusetts also provides two additional safeguards for its residents: the Contraceptive Equity Law, which requires that employer-sponsored health insurance plans that cover preventive services to provide the same coverage for contraceptive services[66]; and the ACCESS Act, which would eliminate cost-sharing fees for certain employer-sponsored insurance plans.[67] Neither protection, however, applies to self-insured employer plans, which are governed by the Employee Retirement Income Security Act ("ERISA").[68]

The Commonwealth could see women shift their coverage schemes by the thousands. Massachusetts' dually-insured population is already sizable, and these women may have to rely on Medicaid to qualify for birth control benefits. Data from the Census Bureau indicates that an estimated 55,913 females aged 15 to 44 years

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[64] Kaiser Family Found., *Status*, *supra*.
[65] *See* 130 C.M.R. §§ 450.316-221.
[66] S*ee* Mass. St. 2002, c. 49; G.L. c. 175, § 47W; G.L. c. 176A, § 8W; G.L. c. 176B, § 4W; G.L c. 176G, § 4O.
[67] *See* Mass. St. 2017, c. 120.
[68] 29 U.S.C. §§ 1144(a), (b)(2)(A).

old in Massachusetts had both Medicaid and employer-sponsored insurance coverage in 2016 (the last year for which data are available as of August 2018).[69] Additionally, federal data indicate that about half (51.6%) of Massachusetts residents with employer-sponsored insurance coverage had self-funded insurance plans.[70] This suggests that roughly 29,000 women with self-funded employer-sponsored health insurance in Massachusetts are also covered by Medicaid. If their employers refuse to offer contraceptive coverage, Medicaid must cover those services instead and would incur financial costs for these services. In addition, should the IFRs go into effect, more women might apply for Medicaid coverage for the sole purpose of obtaining coverage for contraceptives, even if they already have private insurance coverage.

For every woman who loses employer coverage and instead receives contraceptive services through Medicaid provider like MassHealth, MassHealth must pay approximately $376 per year,[71] of which the Commonwealth would bear

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[69] Appendix C, CPS Table Creator, *supra* ("App. C"). All notations on the document were made by *amicus* Professor Leighton Ku.

[70] Agency for Healthcare Res. & Quality, *Percent of Private Sector Enrollees that Are Enrolled in Self-Insured Plans*, Med. Expenditure Panel Surv. (2017), http://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2017/tiib2b1.htm.

[71] Data about the costs of contraceptive coverage in MassHealth is not available. To estimate these costs, *amici* used data from California's Medicaid family planning program, Family PACT for state fiscal year 2014-15, adjusted for inflation to 2018 dollars. Cal. Dep't of Health Care Servs. Off. of Family Plan., *Family PACT Program Report: Fiscal Year 2014-2015*.

10% of total Medicaid costs, or about $38 per year.[72] Because the initial cost for long-acting reversible contraceptives are about twice as high,[73] the costs for the most effective methods would be about $750 per year, translating to a cost to the Commonwealth of $75 per year per woman who loses coverage. The IFRs' new exemptions will, therefore, force the Commonwealth to incur far more than an "identifiable trifle" to pay for this coverage, which would otherwise be covered by employer plans.

2. Title X Clinics and Community Health Centers.

Many women who are unable to obtain free or reduced-price contraceptive services may turn to safety net health facilities, particularly community health centers and publicly-funded family planning clinics. Community health centers, authorized under Section 330 of the Public Health Service Act, are non-profit clinics that provide primary care services, including contraceptive methods and related services.[74] Family planning clinics, also called Title X clinics because they are authorized by Title X of the Public Health Service Act,[75] specialize in provision of family planning services; some Title X facilities are affiliated with community

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http://www.familypact.org/Research/reports/FamPACT_AR1415_CMIOapproved_OFP_FR201415.pdf.

[72] *See* 42 U.S.C. § 1396b(a)(5).

[73] Trussell, *Achieving Cost-Neutrality*, *supra*.

[74] 42 U.S.C. § 254b.

[75] 42 U.S.C. §§ 300-300a-6.

health centers or other health facilities. These clinics make contraception services available for free to poor patients or use sliding fee scales for those with higher incomes.[76]

These safety net facilities provide care to a considerable number of women. In 2015, 105,100 Massachusetts women received contraceptive services at publicly-funded family planning clinics, including 50,860 at community health centers; 19,160 at Planned Parenthood centers; and 35,080 at other publicly-funded facilities, such as hospitals or other clinics.[77] Of these patients, 72,150 received care at a Title X-funded clinic.[78]

The Commonwealth bears a portion of the costs for these facilities in the form of reimbursements from the Commonwealth.[79] Community health centers and Title X clinics receive funding from a variety of sources, including from federal grants and state governments. In 2017, federally-funded community health centers received $1.3 billion in state government funding nationwide.[80] According to HRSA

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[76] *See* 42 C.F.R. § 59.2

[77] Frost, J., et al., *Publicly Funded Contraceptive Services at U.S. Clinics, 2015*, Guttmacher Inst. (2017), http://www.guttmacher.org/sites/default/files/report_pdf/publicly_funded_contraceptive_services_2015_3.pdf.

[78] *Id.*

[79] *See* 101 C.M.R. 312.000.

[80] *See* Health Res. & Servs. Admin., *Table 9E—Other Revenues: National Data*, http://bphc.hrsa.gov/uds/datacenter.aspx?q=t9e&year=2017&state=.

data, Massachusetts health centers received $114 million from state government grants and "State/Local Indigent Care Programs" that year, in addition to their federal grants and insurance payments.[81] Some of the state funding in Massachusetts is through its Health Safety Net Program, which provides funding to community health centers and hospitals to help cover uncompensated care costs by uninsured patients.[82] For the 2018 fiscal year, the state of Massachusetts also budgeted $5.6 million to supplement funding for family planning services.[83] At the national level, in 2016, Title X clinics received over $133 million from state governments to supplement their family planning services.[84] Additional funds are provided by local governments and by state residents who may pay for some services.[85]

As these clinics are forced to spend more for contraceptive services because of the increased exemptions claimed by employers under the new IFRs, states will incur additional expenses. Because the safety net clinics have limited funding, if they do not receive insurance reimbursements from Medicaid or private insurance, they must instead provide uncompensated care using their other limited resources

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[81] *See id.*
[82] *Id.*
[83] Commonwealth of Mass., *45131000—Family Health Services*, Budget Summary FY2019 (Aug. 10, 2018), http://budget.digital.mass.gov/bb/gaa/fy2019/app_19/act_19/h45131000.htm.
[84] Off. of Population Aff., *Title X Annual Report*, *supra*, at A-32.
[85] *Id.*

(such as state or federal grant funds). Doing so ultimately limits their ability to serve other needy patients.

These safety net clinics are not universally available and, because the demand for services often exceeds the funds available,[86] many women are already unable to get free or reduced-price contraceptive services from them. For example, 18% of U.S. counties do not have a publicly-funded family planning clinic; and the capacity of the clinics in counties that do have them is limited.[87] While both the federal government and the states help finance Medicaid and safety net services for contraception, these services are not available to all women, and many women will have no recourse but to pay for contraception out-of-pocket or go without.

C. The Commonwealth Would Be Directly Harmed Due to Substantial Costs It Would Incur to Provide Care to More Women and Families Facing Unintended Births.

If a woman is unable to afford contraception or secure regular, ongoing contraceptive services through insurance coverage or through another subsidized method, she is at risk of an unintended pregnancy and birth. Unintended or mistimed pregnancies and births can have negative consequences for the women experiencing

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[86] *See* Nat'l Conf. of State Legis., *Community Health Centers: A Primer for Legislators* (Aug. 2011), http://www.ncsl.org/portals/1/documents/health/CHCPrimer811.pdf.

[87] Guttmacher Inst., *Fact Sheet: Unplanned Pregnancy in the United States* (Sep. 2016), http://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states (JA 1127-30).

them, the children born, their communities, and the states in which they live. Lack of effective contraception can lead to unintended pregnancies, along with accompanying medical concerns such as pregnancy complications and miscarriages.[88] Unplanned births may also lead to medical complications for mothers and babies, as well as serious economic and social consequences for mothers and their families.[89] These problems are more serious for young, poor and/or unmarried women.[90]

A spike in unintended pregnancies creates substantial costs for state Medicaid programs. In Massachusetts, pregnant women are eligible for MassHealth with incomes up to 205% of the poverty line, significantly higher than the eligibility level for non-pregnant women.[91] Even if the women who lose privately insured contraceptive coverage are neither eligible for nor participating in MassHealth before they become pregnant, they may become eligible for and participate in

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[88] Adler, N., *Contraception and Unwanted Pregnancy*, 5 Behavioral Med. Update 28 (1984); JA 1127-30.
[89] *See* Inst. of Med., *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families* (1995).
[90] JA 1127-30.
[91] *See* Kaiser Family Found., *Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level*, State Health Facts (Jan. 1, 2018), http://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

MassHealth once they become pregnant because of the high costs of prenatal and maternity care and the elevated income eligibility criteria. In addition, once born, their children are very likely to continue to be enrolled in Medicaid programs like MassHealth.[92] MassHealth can also provide secondary coverage for these prenatal, maternity, or early childhood services along with private health insurance coverage, helping such women meet cost-sharing requirements not covered by their private coverage.

Analyses by the Guttmacher Institute indicate that two-thirds (68%) of unplanned births in the U.S. in 2010 were covered by public insurance—Medicaid and to a lesser extent the Children's Health Insurance Program—compared to only 38% of planned births.[93] In Massachusetts, there were 23,200 unplanned births in 2010, of which 13,100 were publicly funded.[94]

When even one woman is unable to obtain effective contraception and instead has an unplanned birth, the public incurs considerable costs. An analysis found that in 2010, the average public cost of an unplanned birth in Massachusetts was $26,779

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[92] Markus, A.R., et al., *Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform*, 23 Women's Health Issues e273 (2013), http://www.whijournal.com/article/S1049-3867(13)00055-8/fulltext.
[93] Sonfield, A. & Kost, K., *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care*, Guttmacher Inst. (Feb. 2015), http://www.guttmacher.org/sites/default/files/report_pdf/public-costs-of-up-2010.pdf.
[94] *Id.*

for maternity care and medical care for the first five years of the child's life or $15,709 for maternity care and the first year of life.[95] Because the Medicaid matching rate for these services for Massachusetts is 50%,[96] the Commonwealth's costs would be approximately $13,400 per unplanned birth for maternity care and the first five years of child medical expenses, or $7,900 for maternity care and first year of life, in 2010 dollars. Due to inflation, these costs would be higher in 2018.

Additional public costs were also incurred for medical care of unplanned births that ended in miscarriages.[97] All told, the public medical costs of unplanned pregnancies in Massachusetts was estimated to be $358 million in 2010, of which $138 million was financed by the state and $220 million paid by the federal government.[98] At the national level, unplanned pregnancies increased public coverage costs by $21 billion in 2010.[99]

While the ultimate cost to the Commonwealth to pay for unplanned pregnancies and births resulting from the loss of employer-sponsored contraceptive coverage is uncertain, there is no doubt that the IFRs, if implemented, would cause the Commonwealth to bear substantial additional financial costs and would

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[95] *Id.*
[96] Mitchell, A., *Medicaid's Federal Medical Assistance Percentage (FMAP)*, Cong. Res. Serv. (Apr. 25, 2018), http://fas.org/sgp/crs/misc/R43847.pdf.
[97] *Id.*
[98] *Id.*
[99] *Id.*

significantly set back Massachusetts's goal of reducing the number of unintended pregnancies and births. These figures do not account for additional social costs incurred, including the lost opportunities for women and the need to help provide social and educational care for children born to needy women. The Commonwealth has demonstrated direct harm far greater than the minimum of what Article III standing requires.

CONCLUSION

For the foregoing reasons, *amici* respectfully request that this Court reverse the decision below.

Respectfully submitted,

AMICI CURIAE
PUBLIC HEALTH SCHOLARS

September 24, 2018

/s/ Christopher Escobedo Hart

Christopher Escobedo Hart (1st Cir. Bar No. 1153981; BBO# 625031)
Emily J. Nash (BBO# 696460)
Foley Hoag LLP
155 Seaport Boulevard
Boston, MA 02210
(617) 832-1232
chart@foleyhoag.com

Certificate of Compliance with Rule 32(a)

This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) and Fed. R. App. P. 29(a)(5) because this brief contains 6,213 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f). It complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and Fed. R. App. P. 32(a)(6) because it has been prepared in 14-point Times New Roman font.

September 24, 2018

/s/ Christopher Escobedo Hart

Attorney for *Amici Curiae* Public Health Scholars

Certificate of Service

I hereby certify that on September 24, 2018, I caused the foregoing to be electronically filed with the United States Court of Appeals for the First circuit by using the CM/ECF system. I certify that the following parties or their counsel of record are registered as ECF Filers and that they will be served by the CM/ECF system.

Julia E. Kobick,
Office of the Attorney General
One Ashburton Place
Boston, Massachusetts 02108

Counsel for Plaintiff-Appellant

Karen Schoen, Esq.
U.S. Department of Justice
950 Pennsylvania Ave. NW, Rm. 7533
Washington, DC 20530

Matthew M. Collette, Esq.
U.S. Department of Justice
950 Pennsylvania Ave. NW, Rm. 7527
Washington, DC 20530

Lowell V. Sturgill Jr., Esq.
U.S. Department of Justice
950 Pennsylvania Ave. NW, Rm. 7241
Washington, DC 20530

Counsel for Defendants-Appellees

September 24, 2018 */s/ Christopher Escobedo Hart*

Attorney for *Amici Curiae* Public Health Scholars

APPENDIX

APPENDIX A

APPENDIX A

LIST OF SIGNATORIES

Leighton Ku, PhD, MPH	Dr. Ku is a Professor in the Department of Health Policy and Management at George Washington University; and a Director at the Center for Health Policy at the Milken Institute School of Public Health.
Laura Attanasio, PhD	Dr. Attanasio is an Assistant Professor at the University of Massachusetts School of Public Health and Health Sciences.
Antonia Biggs, PhD	Dr. Biggs is a Researcher, Department of Obstetrics, Gynecology & Reproductive Health Sciences at the University of California, San Francisco.
Kelly Blanchard, MSc	Ms. Blanchard is President of Ibis Reproductive Health.
Alan B. Cohen, ScD	Mr. Cohen is a Research Professor of Markets, Public Policy and Law at the Questrom School of Business at Boston University.
Eugene Declercq, PhD	Dr. Declercq is a Professor and Associate Dean in the Community Health Sciences Department at the Boston University School of Public Health.
Diana Greene Foster, PhD	Dr. Foster is a Professor, Department of Obstetrics, Gynecology & Reproductive Sciences and Director of Research, Advancing New Standards in Reproductive Health (ANSIRH) at University of California at San Francisco;
Jill Goldstein, PhD	Dr. Goldstein is a Professor of Psychiatry and Medicine, Harvard Medical School; Executive Director, Women, Heart and Brain Global Initiative, Massachusetts General Hospital; and Helen T. Moershner Endowed MGH Research Institute Chair in Women's Health.
Dora Hughes, MD, MPH	Dr. Hughes is an Associate Research Professor, Department of Health Policy and Management at the George Washington University Milken Institute School of Public Health.
Hadine Joffe, MD, MSc	Dr. Joffe is the Paula A. Johnson Associate Professor of Psychiatry in the Field of Women's Health and Executive

	Director, at the Mary Horrigan Connors Center for Women's Health and Gender Biology; and Vice Chair for Research, Department of Psychiatry at Harvard Medical School
Jon Kingsdale, PhD	Dr. Kingsdale is a Sr. Strategy Advisor for Wakely Consulting; Associate Professor of the Practice at Boston University School of Public Health; and an Adjunct Professor at Brown University
Nancy Krieger, PhD	Dr. Krieger is a Professor of Social Epidemiology and American Cancer Society Clinical Research Professor, Department of Social and Behavioral Sciences, Harvard T.H. Chan School of Public Health.
Bruce Landon, MD, MBA, MSc	Professor of Health Care Policy at Harvard Medical School and a Professor of Medicine at Beth Israel Deaconess Medical Center.
Jeffrey Levi, PhD	Dr. Levi is a Professor in the Department of Health Policy and Management at the Milken School of Public Health at George Washington University.
Michael Lu, MD, MPH	Dr. Lu is a Sr. Associate Dean for Academic, Faculty and Student Affairs and a Professor in the Department of Prevention and Community Health at the Milken Institute School of Public Health at George Washington University.
Lois McCloskey, DrPH	Dr. McCloskey is an Associate Professor, Community Health Sciences Associate Chair, and Community Health Sciences Director in the Maternal & Child Health Center of Excellence at the Boston University School of Public Health.
Lydia Pace, MD, MPH	Dr. Pace is an Assistant Professor, Harvard Medical School; and Associate Physician, Division of Women's Health, Brigham and Women's Hospital; Director, Women's Health Policy and Advocacy, Connors Center for Women's Health and Gender Biology, Brigham and Women's Hospital.
Sara Rosenbaum, JD	Ms. Rosenbaum is a Harold and Jane Hirsh Professor at the Department of Health Policy and Management at the Milken Institute School of Public Health at George Washington University.
Ben Sommers, MD, PhD	Dr. Sommers is an Associate Professor of Health Policy and Economics, Department of Health Policy and

	Management at Harvard T.H. Chan School of Public Health.
Joel Teitelbaum, JD, LLM	Mr. Teitelbaum is an Associate Professor and Director of the Hirsh Health Law and Policy Program in the Department of Health Policy & Management at the Milken Institute School of Public Health at George Washington University
Susan Wood, PhD	Dr. Wood is a Professor of Health Policy and Management and a Director at the Jacobs Institute of Women's Health at the Milken Institute School of Public Health at George Washington University

APPENDIX B

Current Population Survey (CPS)

CPS Table Creator

CPS Data Collected in Year: 2017

Persons - All

(Numbers in Whole Numbers)

Female		Totals	Age		
			00 to 14	15 to 44	45 to 80+
Totals	Totals	163,433,445	29,841,822	63,435,260	70,156,363
	Health Insurance: Employment-Based Ins in 2016				
	Covered	89,381,143	16,142,933	38,984,856	34,253,354
	Not Covered	74,052,302	13,698,890	24,450,404	35,903,009
State					
AL	Totals	2,492,287	442,326	945,952	1,104,009
	Health Insurance: Employment-Based Ins in 2016				
	Covered	1,303,879	215,239	578,336	510,304
	Not Covered	1,188,408	227,087	367,616	593,705
AK	Totals	350,376	77,861	143,822	128,693
	Health Insurance: Employment-Based Ins in 2016				
	Covered	194,634	41,038	80,071	73,525
	Not Covered	155,742	36,823	63,751	55,168
AZ	Totals	3,503,311	662,036	1,333,138	1,508,137
	Health Insurance: Employment-Based Ins in 2016				
	Covered	1,670,754	312,985	715,649	642,120
	Not Covered	1,832,558	349,051	617,490	866,017
AR	Totals	1,509,670	279,556	578,744	651,370

Total US Women 15-44 with Employer Sponsored Insurance

	Female	Totals	Age		
			00 to 14	15 to 44	45 to 80+
	Health Insurance: Employment-Based Ins in 2016				
	Covered	734,046	141,258	327,191	265,597
	Not Covered	775,624	138,298	251,554	385,773
CA	Totals	19,729,203	3,686,782	8,040,943	8,001,477
	Health Insurance: Employment-Based Ins in 2016				
	Covered	10,253,389	1,807,547	4,613,332	3,832,509
	Not Covered	9,475,814	1,879,235	3,427,611	4,168,968
CO	Totals	2,758,563	517,671	1,123,212	1,117,680
	Health Insurance: Employment-Based Ins in 2016				
	Covered	1,592,354	306,145	743,796	542,413
	Not Covered	1,166,209	211,526	379,416	575,267
CT	Totals	1,810,805	298,471	667,375	844,959
	Health Insurance: Employment-Based Ins in 2016				
	Covered	1,116,277	158,121	442,678	515,478
	Not Covered	694,528	140,350	224,696	329,482
DE	Totals	489,611	83,632	178,295	227,684
	Health Insurance: Employment-Based Ins in 2016				
	Covered	271,751	43,528	104,344	123,879
	Not Covered	217,860	40,104	73,951	103,805
DC	Totals	359,145	53,255	184,807	121,083
	Health Insurance: Employment-Based Ins in 2016				
	Covered	210,993	25,717	120,286	64,990
	Not Covered	148,151	27,538	64,520	56,093
FL	Totals	10,592,893	1,676,180	3,793,123	5,123,590
	Health Insurance: Employment-Based Ins in 2016				
	Covered	4,896,364	808,536	2,061,096	2,026,732
	Not Covered	5,696,529	867,644	1,732,027	3,096,858

Female		Totals	Age		
			00 to 14	15 to 44	45 to 80+
GA	Totals	5,295,102	1,027,603	2,123,679	2,143,820
	Health Insurance: Employment-Based Ins in 2016				
	Covered	2,795,419	502,055	1,256,686	1,036,679
	Not Covered	2,499,683	525,548	866,994	1,107,141
HI	Totals	704,556	125,875	263,133	315,548
	Health Insurance: Employment-Based Ins in 2016				
	Covered	446,108	86,836	179,692	179,580
	Not Covered	258,448	39,039	83,441	135,968
ID	Totals	842,667	174,965	326,877	340,825
	Health Insurance: Employment-Based Ins in 2016				
	Covered	459,421	88,450	211,896	159,075
	Not Covered	383,246	86,516	114,981	181,750
IL	Totals	6,434,978	1,173,487	2,521,760	2,739,731
	Health Insurance: Employment-Based Ins in 2016				
	Covered	3,714,137	671,348	1,593,617	1,449,171
	Not Covered	2,720,842	502,139	928,143	1,290,560
IN	Totals	3,335,781	626,356	1,294,634	1,414,791
	Health Insurance: Employment-Based Ins in 2016				
	Covered	1,913,003	362,462	874,209	676,333
	Not Covered	1,422,778	263,895	420,425	738,458
IA	Totals	1,561,595	292,098	594,503	674,994
	Health Insurance: Employment-Based Ins in 2016				
	Covered	917,463	173,406	408,138	335,919
	Not Covered	644,132	118,692	186,365	339,075
KS	Totals	1,442,944	291,566	553,264	598,114
	Health Insurance: Employment-Based Ins in 2016				
	Covered	847,563	190,560	355,736	301,267

	Female	Totals	Age		
			00 to 14	15 to 44	45 to 80+
	Not Covered	595,381	101,006	197,528	296,847
KY	Totals	2,233,803	405,129	848,166	980,507
	Health Insurance: Employment-Based Ins in 2016				
	Covered	1,104,029	179,678	469,597	454,754
	Not Covered	1,129,774	225,451	378,570	525,753
LA	Totals	2,375,052	445,431	942,617	987,004
	Health Insurance: Employment-Based Ins in 2016				
	Covered	1,120,514	186,335	488,633	445,546
	Not Covered	1,254,538	259,095	453,985	541,458
ME	Totals	673,233	101,581	229,235	342,417
	Health Insurance: Employment-Based Ins in 2016				
	Covered	378,715	53,388	143,653	181,674
	Not Covered	294,518	48,193	85,582	160,743
MD	Totals	3,083,293	544,225	1,188,784	1,350,284
	Health Insurance: Employment-Based Ins in 2016				
	Covered	1,897,531	328,737	784,849	783,945
	Not Covered	1,185,762	215,488	403,935	566,339
MA	Totals	3,485,240	557,915	1,365,299	1,562,026
	Health Insurance: Employment-Based Ins in 2016				
	Covered	2,084,126	350,308	878,422	855,396
	Not Covered	1,401,114	207,607	486,876	706,630
MI	Totals	5,013,957	854,279	1,884,043	2,275,636
	Health Insurance: Employment-Based Ins in 2016				
	Covered	3,053,800	520,968	1,227,356	1,305,476
	Not Covered	1,960,157	333,311	656,687	970,160
MN	Totals	2,757,326	524,788	1,056,574	1,175,964
	Health Insurance: Employment-Based Ins in 2016	1,697,702	378,566	750,543	568,592

Massachusetts Women 15-44 with Employer-Sponsored Insurance

	Female	Totals	Age		
			00 to 14	15 to 44	45 to 80+
	Covered				
	Not Covered	1,059,624	146,222	306,031	607,372
MS	Totals	1,528,850	294,545	589,170	645,135
	Health Insurance: Employment-Based Ins in 2016				
	Covered	714,185	129,005	328,650	256,531
	Not Covered	814,665	165,540	260,520	388,604
MO	Totals	3,069,040	546,369	1,175,446	1,347,225
	Health Insurance: Employment-Based Ins in 2016				
	Covered	1,688,820	301,099	755,478	632,244
	Not Covered	1,380,220	245,270	419,969	714,981
MT	Totals	516,294	91,641	189,863	234,790
	Health Insurance: Employment-Based Ins in 2016				
	Covered	257,181	48,140	109,940	99,101
	Not Covered	259,114	43,501	79,924	135,689
NE	Totals	950,275	188,567	373,850	387,858
	Health Insurance: Employment-Based Ins in 2016				
	Covered	562,411	120,215	264,349	177,846
	Not Covered	387,865	68,353	109,500	210,012
NV	Totals	1,479,605	276,195	586,927	616,484
	Health Insurance: Employment-Based Ins in 2016				
	Covered	826,170	174,756	378,108	273,306
	Not Covered	653,436	101,439	208,819	343,178
NH	Totals	667,578	100,318	242,520	324,740
	Health Insurance: Employment-Based Ins in 2016				
	Covered	416,902	59,687	174,521	182,693
	Not Covered	250,676	40,631	67,999	142,047
NJ	Totals	4,546,978	807,493	1,688,630	2,050,855

	Female	Totals	Age		
			00 to 14	15 to 44	45 to 80+
	Health Insurance: Employment-Based Ins in 2016				
	Covered	2,743,288	524,544	1,120,342	1,098,402
	Not Covered	1,803,690	282,949	568,288	952,453
NM	Totals	1,041,628	196,766	389,807	455,055
	Health Insurance: Employment-Based Ins in 2016				
	Covered	440,948	70,296	180,935	189,717
	Not Covered	600,680	126,470	208,872	265,339
NY	Totals	10,080,970	1,707,602	3,956,614	4,416,755
	Health Insurance: Employment-Based Ins in 2016				
	Covered	5,734,711	936,171	2,506,672	2,291,868
	Not Covered	4,346,259	771,431	1,449,942	2,124,887
NC	Totals	5,204,948	934,544	1,996,352	2,274,052
	Health Insurance: Employment-Based Ins in 2016				
	Covered	2,629,992	441,722	1,099,258	1,089,012
	Not Covered	2,574,956	492,822	897,094	1,185,040
ND	Totals	364,580	73,210	147,316	144,053
	Health Insurance: Employment-Based Ins in 2016				
	Covered	219,918	43,766	105,538	70,615
	Not Covered	144,662	29,445	41,778	73,438
OH	Totals	5,864,079	1,053,131	2,180,041	2,630,907
	Health Insurance: Employment-Based Ins in 2016				
	Covered	3,301,140	587,644	1,378,444	1,335,052
	Not Covered	2,562,939	465,487	801,596	1,295,855
OK	Totals	1,964,690	402,546	752,854	809,290
	Health Insurance: Employment-Based Ins in 2016				
	Covered	1,063,073	181,653	510,579	370,841
	Not Covered	901,617	220,893	242,275	438,449

Female		Totals	Age		
			00 to 14	15 to 44	45 to 80+
OR	Totals	2,075,690	350,310	808,898	916,482
	Health Insurance: Employment-Based Ins in 2016				
	Covered	1,095,505	182,674	505,452	407,379
	Not Covered	980,185	167,637	303,446	509,103
PA	Totals	6,455,620	1,088,659	2,351,247	3,015,714
	Health Insurance: Employment-Based Ins in 2016				
	Covered	3,945,318	706,449	1,644,357	1,594,513
	Not Covered	2,510,301	382,210	706,890	1,421,202
RI	Totals	536,587	81,990	208,120	246,477
	Health Insurance: Employment-Based Ins in 2016				
	Covered	310,942	51,075	136,185	123,682
	Not Covered	225,646	30,915	71,935	122,795
SC	Totals	2,549,576	457,566	943,474	1,148,536
	Health Insurance: Employment-Based Ins in 2016				
	Covered	1,333,334	238,408	571,194	523,731
	Not Covered	1,216,243	219,158	372,280	624,805
SD	Totals	424,696	88,366	156,829	179,501
	Health Insurance: Employment-Based Ins in 2016				
	Covered	218,533	49,616	95,557	73,360
	Not Covered	206,163	38,750	61,272	106,141
TN	Totals	3,399,872	620,359	1,292,622	1,486,891
	Health Insurance: Employment-Based Ins in 2016				
	Covered	1,738,038	322,816	734,509	680,713
	Not Covered	1,661,834	297,543	558,113	806,178
TX	Totals	14,050,738	3,005,484	5,806,597	5,238,657
	Health Insurance: Employment-Based Ins in 2016				
	Covered	7,483,400	1,536,529	3,361,303	2,585,568

	Female	Totals	Age		
			00 to 14	15 to 44	45 to 80+
	Not Covered	6,567,338	1,468,956	2,445,294	2,653,088
UT	Totals	1,527,195	372,720	675,029	479,445
	Health Insurance: Employment-Based Ins in 2016				
	Covered	980,315	258,125	469,606	252,584
	Not Covered	546,880	114,595	205,424	226,862
VT	Totals	312,748	45,173	114,990	152,585
	Health Insurance: Employment-Based Ins in 2016				
	Covered	171,666	24,765	74,720	72,181
	Not Covered	141,082	20,408	40,270	80,404
VA	Totals	4,243,906	752,814	1,658,630	1,832,461
	Health Insurance: Employment-Based Ins in 2016				
	Covered	2,500,723	471,049	1,119,688	909,985
	Not Covered	1,743,183	281,765	538,942	922,476
WA	Totals	3,657,904	661,505	1,452,620	1,543,779
	Health Insurance: Employment-Based Ins in 2016				
	Covered	2,020,320	345,501	939,350	735,469
	Not Covered	1,637,584	316,004	513,270	808,311
WV	Totals	912,961	147,505	325,198	440,258
	Health Insurance: Employment-Based Ins in 2016				
	Covered	458,104	72,460	191,635	194,010
	Not Covered	454,857	75,045	133,564	246,248
WI	Totals	2,887,928	516,167	1,081,664	1,290,097
	Health Insurance: Employment-Based Ins in 2016				
	Covered	1,689,897	294,782	748,119	646,996
	Not Covered	1,198,032	221,385	333,545	643,101
WY	Totals	283,116	57,208	107,973	117,935
	Health Insurance: Employment-Based Ins in 2016	162,342	36,778	70,562	55,002

	Female	**Totals**		**Age**	
			00 to 14	**15 to 44**	**45 to 80+**
	Covered				
	Not Covered	120,774	20,430	37,411	62,933

Inferences should be made with extreme caution when the cell sizes are small. To examine cell sizes, select "Display Unweighted Record Counts" under the Statistics Option.

Some CPS questions, such as income, ask about the previous year. Others, such as age, refer to the time of the survey. The column labels indicate any subject with a reference year which differs from the survey year.

Current Population Survey, Annual Social and Economic Supplement, 2017

Source: U.S. Census Bureau

Source: U.S. Census Bureau | Current Population Survey (CPS) |??? Last Revised:

APPENDIX C

Current Population Survey (CPS)

CPS Table Creator

CPS Data Collected in Year: 2017

Persons - All

(Numbers in Whole Numbers)

State: MA & Female		Totals	Health Insurance: Medicaid in 2016	
			Covered	Not Covered
Totals	Totals	3,485,240	782,694	2,702,546
	Health Insurance: Employment-Based Ins in 2016			
	Covered	2,084,126	149,108	1,935,018
	Not Covered	1,401,114	633,587	767,528
Age				
00 to 14	Totals	557,915	189,592	368,323
	Health Insurance: Employment-Based Ins in 2016			
	Covered	350,308	47,180	303,128
	Not Covered	207,607	142,413	65,195
15 to 44	Totals	1,365,299	312,067	1,053,232
	Health Insurance: Employment-Based Ins in 2016			
	Covered	878,422	55,913	822,510
	Not Covered	486,876	256,154	230,722
45 to 80+	Totals	1,562,026	281,035	1,280,991
	Health Insurance: Employment-Based Ins in 2016			
	Covered	855,396	46,015	809,380
	Not Covered	706,630	235,020	471,611

Massachusetts women 15-44 with both Medicaid & Employer -Sponsored Insurance

Inferences should be made with extreme caution when the cell sizes are small. To examine cell sizes, select "Display Unweighted Record Counts" under the Statistics Option.

Some CPS questions, such as income, ask about the previous year. Others, such as age, refer to the time of the survey. The column labels indicate any subject with a reference year which differs from the survey year.

Current Population Survey, Annual Social and Economic Supplement, 2017

Source: U.S. Census Bureau