No. 18-1514

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

COMMONWEALTH OF MASSACHUSETTS,

Plaintiff-Appellant,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants-Appellees,

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

AMICUS BRIEF OF 13 CITIES, COUNTIES, AND LOCAL AGENCIES IN SUPPORT OF PLAINTIFFS-APPELLANTS

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STATEMENT OF COMPLIANCE WITH RULE 29

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

INTERESTS OF AMICI

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

Amici have a unique interest in the IFRs as local governments and providers of safety-net services for diverse communities. Essential healthcare services provided and/or subsidized by amici, often through their own healthcare systems, include sexual and reproductive health services such as contraception, pregnancy testing,

family planning services, teen-sensitive sexual and reproductive health services, sexually transmitted infection screening, health education, and community outreach. Many of these services are provided to women and their families without regard to ability to pay, and they are central to effective and efficient disease prevention and health promotion programs. Amici recognize that the IFRs will significantly diminish contraceptive coverage and increase the rate of unintended pregnancy throughout the nation,[1] causing Amici to bear significant public health and financial burdens.

INTRODUCTION

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

When Congress passed the ACA, it recognized the crucial role of contraceptive access for individual self-determination and broader public health goals. The ACA

[1] *See, e.g.*, Resolution of the Board of Supervisors of the County of Santa Clara Supporting Access to Contraceptives, BOS-2017-143 (Santa Clara, CA 2017), *available at* https://sccgov.iqm2.com/Citizens/Detail_LegiFile.aspx?Frame=SplitView&MeetingID=8508&MediaPosition=5978.000&ID=89315&CssClass=.

requires that most private health insurance plans cover without cost sharing all 18 distinct contraceptive methods approved for use by women by the U.S. Food and Drug Administration ("FDA").[2] In doing so, it recognized that women in every city, county, and state need contraceptive coverage.

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

State and local governments throughout the nation provide safety-net services to women who lack adequate contraceptive coverage—in the form of subsidized contraceptive services and/or assistance related to unplanned pregnancies. When

[2] U.S. Dep't of Labor, *FAQs About Affordable Care Act Implementation* (Part XXVI) (May 11, 2015), https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xxvi.pdf.

women cannot access reliable and affordable contraception, the increased costs of resulting unplanned pregnancies are borne by state and local governments. These costs are real. If the IFRs take effect, state and local governments will not only have to provide contraceptive services more broadly, but also—as women lose contraceptive coverage and unplanned pregnancies increase—furnish additional critical services and medical care. As unplanned pregnancies take a financial toll on families, those families may slip out of private health coverage altogether and rely more heavily on safety-net care for their health needs. Because of these widespread direct and indirect harms to state and local governments throughout the country, Amici support reversal of the District Court opinion.

ARGUMENT

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

The ACA's contraceptive coverage requirement ensures that a woman can choose appropriate contraception without regard to upfront costs or other insurance considerations that might make a less effective or medically inappropriate method more affordable. Three of the most commonly used methods of contraception—oral contraception (the "pill"), female sterilization, and intrauterine devices ("IUDs")[3]—

[3] *See* Megan L. Kavanaugh & Jenna Jerman, *Contraceptive Method Use in the United States: Trends and Characteristics Between 2008, 2012 and 2014*, 97 Contraception 14, 16 (2018).

are also among the most highly effective.[4] While these methods are ultimately cost-effective, they can have high upfront costs. Without "the contraceptive coverage guarantee, many women would need to pay more than $1,000 to start using one of these methods—nearly one month's salary for a woman working full-time at the federal minimum wage of $7.25 an hour."[5] Even oral contraceptives, which are twice as effective as condoms, require a prescription and can cost over $60 per month without insurance.[6]

While some states have passed laws requiring that health insurance plans include prescription birth control and ensure that contraception not be treated differently than other prescription medications,[7] there are inherent limitations to piecemeal approaches. Such laws do not extend to individuals covered by self-insured health plans governed by the Employee Retirement Income Security Act ("ERISA").[8]

[4] U.S. Food & Drug Admin., *Birth Control Guide* (last visited Sept. 20, 2018), https://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM517406.pdf.

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

[6] *Birth Control Guide*, *supra* note 4; Adam Sonfield, *The Case for Insurance Coverage of Contraceptive Services and Supplies Without Cost-Sharing*, 14 Guttmacher Pol'y Rev. 7, 9-10 (2011).

[7] *Oral Contraceptive Pills*, Kaiser Family Found. 3 (Aug. 17, 2017), https://www.kff.org/womens-health-policy/fact-sheet/oral-contraceptive-pills/.

[8] As the district court acknowledged, because Massachusetts's ACCESS Act does not apply to ERISA plans, it cannot "protect all Massachusetts employees." *Massachusetts v. U.S. Dep't of Health & Hum. Servs.*, 301 F. Supp. 3d 248, 260 (D. Mass. 2018). Indeed,

Accordingly, the ACA has had profound effects on reducing contraceptive costs for women[9] and decreasing women's reliance on publicly funded contraceptive care.[10] Under the IFRs, significant numbers of insured women will lose comprehensive contraceptive coverage, and state and local governments will bear the costs—either through the increased direct costs of subsidizing contraception[11] or the costs of unplanned pregnancies.[12]

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despite the ACCESS Act, approximately 56% of Massachusetts residents—those who are covered by a self-insured plan not subject to the Commonwealth's own contraceptive coverage requirements—would be at risk of losing their no-cost contraceptive coverage if the IFRs were to take effect. *See* Brief for Plaintiff-Appellant at 13, *Massachusetts v. U.S. Dep't of Health & Hum. Servs.*, No. 18-1514 (1st Cir. Sept. 17, 2018). If the IFRs were not currently enjoined on a nationwide basis, Massachusetts would share with its localities the burdens of reduced access to contraceptive coverage.

[9] *See, e.g.*, Adam Sonfield et al., *Impact of the Federal Contraceptive Coverage Guarantee on Out-of-Pocket Payments for Contraceptives: 2014 Update*, 91 Contraception 44 (2015).

[10] *See* Jennifer J. Frost et al., *Contraceptive Needs and Services, 2014 Update*, Guttmacher Inst. (Sept. 2016), https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf; Kinsey Hasstedt, *Through ACA Implementation, Safety-Net Family Planning Providers Still Critical for Uninsured—and Insured—Clients*, Guttmacher Inst. (Aug. 18, 2016), https://www.guttmacher.org/article/2016/08/through-aca-implementation-safety-net-family-planning-providers-still-critical.

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

[12] *See, e.g.*, Jennifer J. Frost et al., *Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program*, 92 Milbank Q. 667, 690-96 (2014).

The IFRs' expanded exemptions to the contraceptive coverage requirement will decrease health coverage of effective contraception, forcing individuals to either pay for such coverage out-of-pocket or to seek contraceptive coverage from available state and local programs. Under the IFRs, some employers could drop contraceptive coverage with minimal or even no notice to employees and beneficiaries, leaving potentially millions of women without contraceptive coverage or care.

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

As pre-ACA studies have repeatedly shown, insurance coverage is crucial for effective and continuous use of family planning methods. For example, a 2007 study showed that uninsured women "were 30% less likely to report using prescription contraceptive methods" than women with some form of insurance.[13] In the obverse, a post-ACA study based on claims data found that "women were less likely to stop using the pill once costs were removed."[14]

Loss of health coverage for contraceptives will likely increase the rate of unplanned pregnancies. Indeed, 95% of unintended pregnancies are attributable to

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

[14] Sonfield, *supra* note 5, at 10 (citing L.E. Pace et al., *Early Impact of the Affordable Care Act on Oral Contraceptive Cost Sharing, Discontinuation, and Nonadherence*, 35 Health Aff. 1616 (2016)).

the one-third of women who do not consistently use contraception.[15] When women suddenly lose health coverage for this care, inconsistent or discontinued use may follow.[16] The unplanned pregnancies that result have direct health and financial repercussions for women, their families, and their communities throughout the nation. The negative health and socioeconomic outcomes associated with unplanned births are well established.[17] "Unplanned pregnancies are associated with delayed initiation of prenatal care and a decreased likelihood of breast-feeding."[18] Short spacing between pregnancies increases the risk of preterm birth and low-birth-weight babies.[19] Furthermore, when women are able to plan their pregnancies, they are better able to invest in their educations and careers, enabling them to contribute more meaningfully to their local economies.[20]

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[15] Sonfield, *supra* note 6, at 9.

[16] Pace et al., *supra* note 14 (associating higher copayments with greater discontinuation and non-adherence rates than was the case with zero copayments).

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

[18] *Id.*

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

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

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

The IFRs run contrary to the ACA's goal of reducing barriers to consistent contraceptive use, and they will cause substantial financial harm to public entities that provide safety-net care. On a national level, one study estimates that unplanned pregnancies and one year of infant medical care cost taxpayers $11 billion annually.[21]

As discussed above, the IFRs will result in a substantial number of women across the U.S. losing employer-sponsored contraceptive coverage—often with little or no notice from employers. While the availability of public contraceptive coverage differs by state, some portion of women will qualify for state- or locally subsidized care either to fill the gap left by private insurers or to provide prenatal and infant health care. In fact, from 2006 to 2010, one in four women who obtained contraceptive services did so at a publicly funded center.[22] Research shows that the ACA's coverage expansions in 2014 decreased the proportion of uninsured U.S. women, which corresponded to a decreased proportion of women relying on publicly

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Goldin & Lawrence F. Katz, *Career and Marriage in the Age of the Pill*, 90 Am. Econ. Rev. 461 (2000).

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

[22] *See* Jennifer J. Frost, *U.S. Women's Use of Sexual and Reproductive Health Services: Trends, Sources of Care and Factors Associated with Use, 1995-2010*, Guttmacher Inst. (May 2013), at 16, https://
www.guttmacher.org/sites/default/files/report_pdf/sources-of-care-2013.pdf.

funded family planning.[23] As the number of women without full contraception coverage rises, this trend will reverse and require state and local governments to once again fill the gaps in coverage.

Although requirements vary from state to state, local governments across the country are responsible for providing a wide range of healthcare services as part of the social safety net.[24] In California, for example, all 58 counties must provide safety-net health services. Cal. Welf. & Inst. Code § 17000. Nationally, localities fund or support safety-net health centers that provide free or reduced-fee services to clients, in addition to other local programs.[25] Family planning services offered may include contraception, pregnancy and sexually transmitted disease testing, and other maternal

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[23] *See* Frost et al., *supra* note 10; Hasstedt, *supra* note 10.

[24] *See Counties' Role in Health Care Delivery and Financing*, Nat'l Ass'n of Cntys. (July 2007), at 3, http://www.naco.org/sites/default/files/documents/Counties'%20Role%20in%20Healthcare%20Delivery%20and%20Financing.pdf; Eileen Salinsky, *Governmental Public Health: An Overview of State and Local Public Health Agencies*, Nat'l Health Pol'y F. (Aug. 18, 2010), at 9-10, https://www.nhpf.org/library/background-papers/BP77_GovPublicHealth_08-18-2010.pdf.

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

and child health services.[26] In 2010, 82% of U.S. counties had at least one safety-net health center providing family planning.[27]

State and local government safety-net providers will inevitably bear a financial burden. Counties throughout the nation provide medical services to low-income individuals, and thousands of public health agencies operate at the local level. Overall, as more employers opt out of contraceptive coverage, more low-income people will seek locally subsidized services—including both low- and no-cost contraceptive services and a wide range of services and assistance for unplanned pregnancies—at a direct cost to local governments. As local health systems already operate at a deficit because of uncompensated costs incurred in serving uninsured and under-insured patients, the IFRs will only exacerbate local fiscal problems.

Nor could states and local governments avoid cost increases by themselves opting out of subsidizing contraceptive care. In the absence of more publicly funded family planning services, there will be more demand for public funding for medical costs related to pregnancy, delivery, and pediatric care.[28] In 2010, every $1.00 invested in publicly funded family planning services saved $7.09 in Medicaid expenditures that

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[26] *See generally* Salinsky, *supra* note 24; *Fact Sheet: Publicly Funded Family Planning Services*, *supra* note 25.

[27] *See Fact Sheet: Publicly Funded Family Planning Services*, *supra* note 25.

[28] *See, e.g.*, Frost et al., *supra* note 12.

would otherwise have been needed to pay for prenatal and early childhood care.[29] State and local jurisdictions will have to fund many of the medical services associated with unintended pregnancies.[30] The IFRs completely ignore the reality that local governments often bear all or part of the costs of providing these services and would suffer adverse fiscal impacts stemming from increased demand.

The Department of Health & Human Services's proposed changes to the Title X family planning program[31] will further exacerbate the IFRs' financial cost to state and local governments. Title X is the federal government's only dedicated family planning funding program, and the proposed rule would effectively exclude one in 10 current Title X providers from the program.[32] Because these providers are often funded from a combination of Title X, state, and local sources, the loss of Title X

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[29] *Id.* at 667.

[30] *See* Adam Sonfield & Kathryn Kost, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, Guttmacher Inst. (Feb. 2015), https://www.guttmacher.org/sites/default/files/report_pdf/public-costs-of-up-2010.pdf.

[31] The proposed rule would (among other things) deny federal funds to family planning providers that offer abortion; end the requirement that Title X sites offer non-directive pregnancy options counseling; prohibit Title X providers from referring patients to abortion services in almost all circumstances; and furnish federal funds to Title X sites presenting "fertility awareness" and abstinence as family planning methods. 83 Fed. Reg. 25,502 (June 1, 2018).

[32] Kinsey Hasstedt, *A Domestic Gag Rule and More: The Administration's Proposed Changes to Title X*, Guttmacher Inst. (June 18, 2018), https://www.guttmacher.org/article/2018/06/domestic-gag-rule-and-more-administrations-proposed-changes-title-x.

funds will put ever greater strain on state and local resources.[33] If states and localities are unable to cover what private insurance and Title X used to provide, some women may be forced to limit or cease contraceptive use.[34] And if the proposed Title X rule takes effect, Title X-funded local health departments will have to increase their capacity by more than 31 percent just to serve all existing Title X patients.[35] Given the role local governments play nationally in providing safety-net services, the proposed Title X rule's exacerbation of the IFRs' harms would be widespread and nationwide in scope.

Finally, local governments are likely to be harmed by the decrease in tax revenues when women with unexpected pregnancies lose economic opportunities. For example, one recent study indicates that women's participation in the economy promotes *overall* economic development in cities.[36] The study found that between

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[33] Adam Sonfield et al., *Assessing the Gap Between the Cost of Care for Title X Family Planning Providers and Reimbursement from Medicaid and Private Insurance* 13-14 (Jan. 2016), https://www.guttmacher.org/sites/default/files/pubs/Title-X-reimbursement-gaps.pdf.

[34] *See, e.g.*, Amanda J. Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, New England J. Med. (2016), https://www.nejm.org/doi/full/10.1056/NEJMsa1511902#t=article.

[35] Kinsey Hasstedt, *Beyond the Rhetoric: The Real-World Impact of Attacks on Planned Parenthood and Title X*, 20 Guttmacher Pol'y Rev. 86, 89 (2017).

[36] Amanda L. Weinstein, *Working Women in the City and Urban Wage Growth in the United States*, 57 J. Regional Sci. 591 (2017).

1980 and 2010, every 10% increase in female labor force participation rates in metropolitan areas was associated with an increase in real wages of nearly 5%.[37] Such growth is significant for governments relying on their tax base to fund public services. Local governments nationwide would likely face irreparable harm as more women miss out on economic opportunities due to unplanned pregnancies.

The fiscal harms that would befall Amici reflect the grave harms to individual health and well-being that result from decreased access to contraception. These harms cannot be overstated, as "[n]o possible way exists to compensate in the future for health problems triggered in the past." *Cmty. Nutrition Inst. v. Butz*, 420 F. Supp. 751, 757 (D.D.C. 1976). And once implemented, the effects of the IFRs are not easily undone due to factors such as the time required for group health plans and health insurance issuers to take coverage "changes into account in establishing their premiums, and in making other changes to the designs of plan or policy benefits," 75 Fed. Reg. 41,730 (July 19, 2010); the cyclical start dates for health insurance plan years, *see* 76 Fed. Reg. 46,624 (Aug. 3, 2010); and lag times between open enrollment periods, *see* 42 U.S.C. § 18031(c)(6).[38] If the IFRs are allowed to take effect, the

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[37] *Id.*

[38] The IFRs took effect on October 6, 2017, one week prior to formal publication in the Federal Register, and they allow as little as thirty days' notice for revocation of contraceptive coverage by an eligible employer. 82 Fed. Reg. 47,813 (Oct. 13, 2017) (Religious Exemption); 82 Fed. Reg. 47,854 (Oct. 13, 2017) (Moral Exemption).

Commonwealth of Massachusetts—and virtually every state and local government throughout the nation—will have to foot the bill for subsidized contraceptive services or assistance related to unplanned pregnancies, while taking a hit to their tax revenues due to lost productivity associated with unplanned pregnancies. These irreparable harms are more than sufficient to support standing.

CONCLUSION

For the foregoing reasons, the district court's judgment should be reversed, and, on remand, the District Court should be instructed to find that the Commonwealth's injuries are sufficient to establish Article III standing.

Dated: September 24, 2018

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit set forth in Federal Rules of Appellate Procedure 29(a)(5) because it contains 3,363 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Microsoft Word 2016 in Garamond 14-point font, a proportionally spaced typeface.

/s/ Laura S. Trice
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CERTIFICATE OF SERVICE

I hereby certify that on September 24, 2018, 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. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

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