XAVIER BECERRA, SBN 118517
Attorney General of California
JULIE WENG-GUTIERREZ, SBN 179277
Senior Assistant Attorney General
R. MATTHEW WISE, SBN 238485
KARLI EISENBERG, SBN 281923
MICHELE L. WONG, SBN 167176
Deputy Attorneys General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7913
Fax: (916) 324-8853
E-mail: Karli.Eisenberg@doj.ca.gov
Attorneys for Plaintiff the State of California

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

THE STATE OF CALIFORNIA; THE STATE OF DELAWARE; THE STATE OF MARYLAND; THE STATE OF NEW YORK; THE COMMONWEALTH OF VIRGINIA,

Plaintiffs,

v.

ERIC D. HARGAN, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF LABOR; U.S. DEPARTMENT OF LABOR; STEVEN MNUCHIN, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF THE TREASURY; U.S. DEPARTMENT OF THE TREASURY; DOES 1-100,

Defendants.

4:17-cv-05783-HSG

STATES' NOTICE OF MOTION AND MOTION FOR PRELIMINARY INJUNCTION, WITH MEMORANDUM OF POINTS AND AUTHORITIES

Date:	Feb. 8, 2018
Time:	2:00 p.m.
Ctrm:	2, 4th Floor
Judge:	Hon. Haywood S. Gilliam, Jr.
Trial Date:	Not set
Action Filed:	October 6, 2017

TO THE DEFENDANTS, AND THEIR COUNSELS OF RECORD:

PLEASE TAKE NOTICE that on February 8, 2018, at 2:00 p.m., in Courtroom 2 of the above-entitled court, located at 1301 Clay Street, Oakland, California, Plaintiffs, the States of California, Delaware, Maryland, New York, and the Commonwealth of Virginia (the States), will and hereby do move this Court for a preliminary injunction staying implementation of the two illegal interim final rules (IFRs), 2017-21851 (the "Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act") and 2017-21852 (the "Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act").[1]

Under Local Rule 7-2, the States bring this motion to request that this Court issue a preliminary injunction, enjoining enforcement of the IFRs. Specifically, the requested relief would enjoin Eric D. Hargan, in his official capacity as Acting Secretary of the U.S. Department of Health & Human Services; U.S. Department of Health and Human Services; R. Alexander Acosta, in his official capacity as Secretary of the U.S. Department of Labor; U.S. Department of Labor; Steven Mnuchin, in his official capacity as Secretary of the U.S. Department of the Treasury; U.S. Department of the Treasury (collectively, Defendants) from implementing the IFRs.

On October 6, 2017, Defendants, without any notice or comment period, issued two IFRs that drastically impair access to contraceptive coverage by allowing *any* employer, health insurer, or individual with religious objections to opt out of the contraceptive-coverage requirement without taking any steps to ensure that women have alternative access to contraceptive coverage. Additionally, the IFRs allow an employer, health insurer, or individual with *moral* objections to opt out of the contraceptive-coverage requirement. The IFRs violate the Administrative Procedure Act (APA), as well as the Establishment Clause of the First Amendment and the Equal Protection Clause of the Fifth Amendment to the U.S. Constitution. The IFRs result in

[1] Simultaneously, the States are filing a motion to shorten time so that this motion can be argued and heard before January 1, 2018.

irreparable harm, are unlawful, and should be enjoined at least until the merits of this case are finally resolved. Unless Defendants are immediately enjoined from further implementing the IFRs, the States will suffer irreparable harm from the repercussions of denying women no-cost contraceptive coverage. Injunctive relief is further supported by the balance of hardships and public interest, both of which heavily favor the States.

WHEREFORE, the States pray that this Court grant a preliminary injunction barring Defendants from implementing the IFRs.

A Memorandum of Points and Authorities setting forth the grounds for this Motion, along with the Declarations of John Arensmeyer, Keisha Bates, Mari Cantwell, Dr. Lawrence Finer, Daniel Grossman, Professor Lisa Ikemoto, Dave Jones, Dr. Hal C. Lawrence, III, MD, Ruth Lytle-Barnaby, Trinidad Navarro, Karen Nelson, Karyl Rattay, Reverend Susan Russell, Jenna Tosh, Ph. D., Jonathan Werberg, and Massey Whorley, and a Proposed Order are filed herewith.

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MEMORANDUM OF POINTS AND AUTHORITIES

INTRODUCTION

Women's access to contraceptive care—and decision whether and when to use contraception—is a fundamental precept of freedom and equality. The Patient Protection and Affordable Care Act (ACA) and its implementing regulations revolutionized women's access to essential health care by guaranteeing "no cost" coverage of all Food and Drug Administration (FDA)-approved contraceptive methods, sterilization, and contraceptive counseling (contraceptive coverage). Since 2012, over 62 million women have benefited from this law. Yet the illegal interim final rules (IFRs) at issue allow an employer or insurer to interfere with a woman's decision whether and when to have children. The States bring this motion to protect the rights of women and families as well as the states' public health and financial interests.

On Friday, October 6, 2017, without any prior notice or comment, Defendants significantly curtailed women's federal guarantee to no-cost contraceptive coverage—and the significant health and economic benefits that come with it—by issuing two IFRs allowing nearly any employer or health insurer to invoke religion or morality to stop providing contraceptive coverage. These regulations became effective immediately. Women offered new health plans by their employers may already have lost contraceptive coverage, while women covered under existing health plans may lose coverage as soon as December. The vast majority of women may be deprived of contraceptive coverage in their health plans when a new plan year begins on January 1, 2018. Some impacted women will seek contraceptive coverage from the States, others will struggle to pay themselves, while still others will be left with no available recourse and forced to forgo this important health and economic benefit. With a surge in the unintended pregnancy rate likely to result, the States and their residents will bear the irreversible effects—worse health for mothers and their children, a greater need for state services to confront these challenges, and a decline in opportunities for women in education and the workplace.

To avert these harms and to preserve the status quo, the States seek a preliminary injunction to enjoin these unlawful IFRs. A preliminary injunction is necessary to ensure that employers and insurers do not eliminate their contraceptive coverage due to IFRs that were illegally

promulgated without notice and comment, are arbitrary and capricious and contrary to law, and violate the Establishment and Equal Protection Clauses of the Constitution.

Defendants' failure to provide notice and comment as required by the Administrative Procedure Act (APA) is alone enough to enjoin the IFRs. Defendants offer no persuasive reason to circumvent the normal rule-making process, relying primarily on their desire to implement the regulations as soon possible. This justification has no legal force. Denied the opportunity to comment before this dramatic step backwards in women's health coverage, the States—and their women residents—have suffered irreparable injury.

Defendants also violated the APA by promulgating IFRs that are not in accordance with the law and exceed their statutory authority. The ACA requires Defendants to promulgate regulations that ensure access to essential health benefits, including preventive services such as contraceptive coverage. The ACA does not authorize Defendants to deny these benefits through IFRs that permit nearly *any* employer to impose their religious and moral beliefs on their workers (and dependents). To the contrary, several provisions within the ACA specifically prohibit Defendants from enacting regulations that discriminate on the basis of gender and that block access to health care. The ACA has ushered in a new era for women's health, where millions of women are benefiting from no-cost contraceptive coverage, including counseling, family planning, access to birth control, and health services for the early detection of sexually transmitted infections. The IFRs reverse this progress without adequate legal justification.

The IFRs are also constitutionally suspect. First, the IFRs violate the Establishment Clause because they have a religious purpose. The principal effect of the IFRs is to advance religion, while placing an undue burden on third parties—women. Second, the IFRs violate the Equal Protection Clause because they discriminate against women. The IFRs single out women's preventive services, depriving only women of essential health benefits required by statute, while serving no important government interest. Thus, the IFRs not only create a gender classification, but are also overtly and covertly discriminatory against women.

As Defendants concede, deprivation of constitutional rights is unquestionably irreparable; similarly, failure to comply with the APA entitles a moving party to an injunction. The

immediate implementation of the IFRs will also inflict irreparable harm upon the States—and women—due to a rise in unintended pregnancies and increased reliance on state services. Given that these legal violations will affect all states and women across the country, a nationwide injunction is appropriate.

LEGAL AND FACTUAL BACKGROUND

I. PROVIDING CONTRACEPTIVE COVERAGE IS OF VITAL IMPORTANCE

The benefits of contraception to women—and ultimately society—are universal. Contraceptives are among the most widely used medical products in the United States, with 99 percent of sexually active women having used at least one type of contraception in her lifetime. By the age of 40, American women have used an average of three or four different methods (some of which are available only by prescription), after considering their relative effectiveness, cost, side effects, drug interactions and hormones, the frequency of sexual conduct, perceived risk of sexually transmitted infections (STIs), the desire for control, and a host of other factors. Decl. of Lawrence Finer [Finer Decl.] ¶ 8; Decl. of John Arensmeyer [Arensmeyer Decl.] ¶ 5 ("Access to contraceptive coverage promotes the financial stability of female entrepreneurs and their employees"). As explained by the American Congress of Obstetricians and Gynecologists (ACOG), "the benefits of contraception are widely recognized and include improved health and well-being, reduced global maternal mortality, health benefits of pregnancy spacing for maternal and child health, female engagement in the work force, and economic self-sufficiency for women." Finer Decl. ¶ 43; Decl. of Hal C. Lawrence [Lawrence Decl.] ¶ 5; *see, e.g.*, Decl. of Dan Grossman [Grossman Decl.] ¶ 7 ("interpregnancy intervals of less than 18 months and high rates of unintended pregnancy are associated with adverse birth outcomes."). Further, as a result of the ACA's contraceptive-coverage requirement, women have saved an average of 20% in out-of-pocket expenses. Grossman Decl. ¶ 9; *see also* Finer Decl. ¶ 32 ("Between fall 2012 and spring 2014 (during which time the coverage guarantee went into wide effect), the proportion of privately insured women who paid nothing out of pocket for the pill increased from 15% to 67%, with similar changes for injectable contraceptives, the vaginal ring and the IUD").

II. THE AFFORDABLE CARE ACT CLEARLY REQUIRES THAT PREVENTIVE SERVICES, INCLUDING CONTRACEPTIVE COVERAGE, BE PROVIDED

The ACA requires that group health insurance plans include women's "preventive care and screenings" and "shall not impose any cost sharing" on the consumer. 42 U.S.C. § 300gg-13(a)(4). In response to this Congressional directive, the U.S. Department of Health and Human Services (HHS) commissioned the nonpartisan Institute of Medicine (IOM) to assemble a diverse, expert committee to determine what should be included in "preventive care" coverage.[2] Following rigorous, independent, and exhaustive review of the scientific evidence, the IOM issued its expert report with a comprehensive set of eight recommendations for implementing women's preventive health care services.[3] These recommendations addressed important gaps in coverage for women.[4] The recommendations include coverage for an annual well-woman preventive care visit, counseling and screening for HIV and domestic violence, services for the early detection of reproductive cancers and sexually transmitted infections, and patient education and counseling for all women with reproductive capacity.[5] Significantly, the IOM recommended that private health insurance plans be required to cover contraceptive methods approved by the FDA without cost-sharing (also known as out-of-pocket costs such as deductibles and copays).[6] The IOM considered these services essential so that women can avoid unwanted pregnancies and space their pregnancies to promote optimal birth outcomes.[7] The IOM also explained that "[c]ost barriers to use of the most effective contraceptive methods are important because long-acting, reversible contraceptive methods" have "high up-front costs."[8]

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[2] Institute of Medicine, Clinical Preventive Services for Women: Closing the Gaps (2011) (hereinafter "IOM Report"), *available at* https://www.nap.edu/read/13181/chapter/1.

[3] *Id*. at 79-156 (chapter 5 generally).

[4] *See id*. at 79-156; *id*. at 109 (under "identified gaps," IOM explained that "systematic evidence reviews and other peer-reviewed students provide evidence that contraception and contraceptive counseling are effective at reducing unintended pregnancies.")

[5] *See id*. at 79-156.

[6] *Id*. at 102-10. Before the ACA, contraceptives accounted for between 30-44% of out-of-pocket health care spending for women. Finer Decl. ¶ 33.

[7] INSTITUTE OF MEDICINE, REPORT BRIEF: CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS 2 (2011) [hereinafter IOM BRIEF], http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps/preventiveservicesforwomenreportbrief_updated2.pdf

[8] IOM Report at 108.

Following the IOM's recommendations on contraceptive coverage, HHS, the U.S. Department of Labor, and the U.S. Department of the Treasury promulgated regulations requiring that employers offering group health insurance plans cover all FDA-approved contraceptive methods. 45 C.F.R. § 147.130(a)(1)(iv); 29 C.F.R. § 2590.715-2713(a)(1)(iv); 26 C.F.R. § 54.9815-2713(a)(1)(iv). In order to effectuate these regulations, HRSA issued comprehensive guidelines that included a list of each type of preventive service, and the frequency with which that service should be offered.[9]

The only category of health plans excluded from the contraceptive-coverage requirement were "grandfathered" plans. 45 C.F.R. § 147.140(a) (defining "grandfathered" health plans as those which have existed continually prior to the ACA's enactment (March 23, 2010) and have not undergone specific changes); 29 C.F.R. § 2590.715-1251 (2010). The purpose of excluding grandfathered plans was to ease individuals into the ACA.[10]

Since the ACA's requirement to cover contraception took effect in 2012, women have saved $1.4 billion, and to date, 62.4 million women have benefited from this coverage.[11] This savings to women has a corresponding fiscal impact on society, including the States. Lawrence Decl. ¶¶ 4-9; Finer Decl. ¶¶ 32-37; Cantwell Decl. ¶ 13 ("The ACA's implementation correlates with a decrease in Family PACT enrollees" in California). The ACA's contraceptive-coverage requirement decreases the number of unintended pregnancies, and thereby the costs associated with those pregnancies. Finer Decl. ¶¶ 32-27. Furthermore, unintended pregnancy is associated with poor birth outcomes and maternal health complications, and thus, the contraceptive-coverage requirement also reduces the number of high-cost births and infants born in poor health. Lawrence Decl. ¶¶ 4-9 ("universal coverage of contraceptives is cost effective and reduces

[9] HEALTH RES. & SERV. ADMIN., WOMEN'S PREVENTIVE SERVICES GUIDELINES (last visited Oct. 13, 2017), https://www.hrsa.gov/womens-guidelines/index.html.

[10] The percentage of individuals covered under grandfathered plans has decreased since the ACA's implementation and in 2017 was only 17 percent of the total marketplace. Kaiser Family Foundation, *Employer Health Benefits 2017 Annual Survey*, *available at* http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2017.

[11] National Women's Law Center, Fact Sheet, (Sep. 2017), *available at* https://nwlc.org/wp-content/uploads/2017/09/New-Preventive-Services-Estimates-3.pdf.

unintended pregnancy and abortion rates." "each dollar spent on publicly funded contraceptive services saves the U.S. health care system nearly $6."); Grossman Decl. ¶ 7.

III. THE PRIOR REGULATORY SCHEME CARVED OUT A PROPERLY TAILORED EXEMPTION AND ACCOMMODATION THAT MAINTAINED WOMEN'S ACCESS TO EQUAL HEALTH CARE COVERAGE WHILE BALANCING RELIGIOUS LIBERTY

The ACA itself does not create exemptions or accommodations; nor does it delegate federal agencies the ability to create exemptions or accommodations. Over the past five years, however, the federal government has implemented a series of tailored exemptions and accommodations in order to reconcile the sincerely-held religious beliefs of a narrow category of employers and the compelling interest in access to contraception. *See* 75 Fed. Reg. 41726 (2010); 76 Fed. Reg. 46621 (2011); 77 Fed. Reg. 8725 (2012); 78 Fed. Reg. 39870 (2013); 79 Fed. Reg. 51092 (2014); 80 Fed. Reg. 41318 (2015).

The federal government carefully crafted a narrowly tailored exemption for religious employers, including churches and their integrated auxiliaries, conventions, and associations of churches. *See* 76 Fed. Reg. 46, 621 (2011); 78 Fed. Reg. 8456, 8458 (2013). This allowed these religious employers to seek an exemption from the contraceptive-coverage requirement consistent with the Internal Revenue Code. *See* 45 C.F.R. § 147.131(a) (defining "religious employers"); 26 C.F.R. § 54.9815-2713A(a).[12]

In addition to this narrow exemption, in 2013, the federal government created an accommodation for nonprofit organizations with religious objections to contraceptive coverage. 45 C.F.R. § 147.131(b); 78 Fed. Reg. 12739871, 398892-389897 (2013). Under the accommodation process—a process inapplicable to exempt employers—a nonprofit employer

[12] For purposes of this exemption, a religious employer was originally limited to one that: (1) Has the inculcation of religious values as its purpose; (2) primarily employs persons who share its religious tenets; (3) primarily serves persons who share its religious tenets; and (4) is a nonprofit organization described in section 6033(a)(1) and (a)(3)(A)(i) or (iii) of the Code. Section 6033(a)(3)(A)(i) and (iii) of the Code refers to churches, their integrated auxiliaries, and conventions or associations of churches, as well as to the exclusively religious activities of any religious order. 78 Fed. Reg. 8456, 8458 (2013). "Some commenters brought to the Departments' attention [during proper notice and comment] that" certain religious entities would not qualify under the fourth prong, such as a church that runs a parochial school. *Id*. Therefore, taking account of these comments, the Defendants proposed to simplify and clarify the definition of religious employer by eliminating the first three prongs and clarifying the fourth prong of the definition. 78 Fed. Reg. 39870-01, 39874 (2013).

certified its religious objection to the federal government or to the insurer, and then the insurer was responsible for providing separate contraceptive coverage for female employees. 45 C.F.R. § 147.131(b) & (c)(2). The health insurer covered the contraceptive benefits and services, and, in turn, could be reimbursed with the Federally-Facilitated Marketplace (FFM) fee for providing such benefits and services. 80 FR 41346 (2015). The accommodation process ensured a seamless mechanism for female employees to receive the statutorily-entitled contraceptive coverage that their nonprofit employers did not pay for or facilitate. 45 C.F.R. § 147.131(b).[13] In short, the accommodation process balanced the rights of female employees to equal health care coverage while safeguarding religiously-affiliated nonprofit employers' ability to opt out of providing this coverage. *See* 80 FR 41318 (2015) (HHS regulation); 45 C.F.R. § 147.131(c)-(d). This scheme guaranteed that those female employees would not be adversely affected by their employers' decision to opt out of providing coverage and that no woman was falling through the proverbial cracks. 45 C.F.R. § 147.131(c)-(d); 158 Cong. Rec. S375 at H628 (daily ed. Feb. 8, 2012) (noting that these regulations respect the rights of religious institutions without "trampl[ing] on the rights of others"); *id*. at H586 (statement that the accommodation "represents a respectful balance between religious persons and institutions and individual freedom"); *id.* at H625 (noting that the accommodation "strikes a delicate balance representing the rights of both religious ideology opposed to birth control and American women").

The religious accommodation was later expanded to include certain closely-held for-profit organizations with religious objections to providing contraceptive care, consistent with the Court's decision in *Burwell v. Hobby Lobby Stores, Inc*., 134 S. Ct. 2751 (2014); 80 FR 41318 (2015); 45 C.F.R. § 147.131(b)(4). Notably, the Supreme Court in *Hobby Lobby* recognized the accommodation process as "a system that seeks to respect the religious liberty of religious nonprofit corporations while ensuring that the [female] employees of these entities have precisely

[13] CENTER FOR CONSUMER INFO. & INS. OVERSIGHT, WOMEN'S PREVENTIVE SERVICES COVERAGE AND NON-PROFIT RELIGIOUS ORGANIZATIONS, CENTERS FOR MEDICARE & MEDICAID SERV. (last visited Oct. 13, 2017), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/womens-preven-02012013.html.

the same access to all FDA-approved contraceptives as [female] employees of companies whose owners have no religious objections to providing such coverage." 134 S. Ct. at 2759.

More recently, the Supreme Court in *Zubik v. Burwell*, 136 S. Ct. 1557, 1559 (2016), was faced with the issue of whether the accommodation process, requiring religious nonprofit organizations to submit a form stating their objection, substantially burdened the organizations' exercise of religion, in violation of the Religious Freedom Restoration Act of 1993 (RFRA). In contrast to the position taken under the current Administration in issuing the IFRs, in *Zubik* the federal government argued that complying with the accommodation process was not a violation of RFRA. Following oral argument, the Supreme Court requested supplemental briefing to determine whether a compromise could be reached on the issue. *Id*. at 1559-1560. After briefing, the Court vacated and remanded the matter, instructing that: "the parties on remand should be afforded an opportunity to arrive at an approach going forward that accommodates [religious organizations'] religious exercise while *at the same time ensuring that women covered by* [religious organizations'] *health plans receive full and equal health coverage, including contraceptive coverage.*" *Id*. at 1560 (emphasis added) (internal quotation marks and citation omitted).

The process and distinction in terminology between an exemption and accommodation was significant. Under the "exemption," the "religious employer," as defined by statute, was entirely exempt from providing contraceptive coverage. In contrast, an "accommodation" allowed the religious nonprofits to avoid providing direct coverage, but still ensured that their female employees had access to their statutorily-entitled health care benefits.

In July 2016, in response to the issues raised in *Zubik*, the federal government published a Request for Information (RFI), seeking input on whether and how the regulations exempting religious nonprofits could be changed to resolve the objections asserted by plaintiffs in *Zubik*, while still ensuring that the affected women receive full and equal health coverage, including contraceptive coverage. Over 54,000 comments were submitted. Notably, the July 2016 RFI did not propose a "moral" exemption and did not propose expanding the religious exemption to all employers, insurers, and individuals. The July 2016 RFI was limited to the question posed by

Zubik: is there "an approach going forward that accommodates [religious organizations'] religious exercise while at the same time ensuring that women covered by [religious organizations'] health plans receive full and equal health coverage, including contraceptive coverage." *Zubik*, 136 S.Ct. at 1560. Therefore, this RFI is distinguishable from the IFRs at issue in this case.

On May 4, 2017, President Trump issued Executive Order 13798, "Promoting Free Speech and Religious Liberty," that explicitly targeted the women's preventive health care provided under the ACA. ECF No. 24-1 at 2. The President instructed that the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services consider issuing amended regulations to address objections to the contraceptive-coverage requirement. *Id*. at 8.

IV. DEFENDANTS PROMULGATED NEW IFRS THAT PERMIT EMPLOYERS TO IMPOSE THEIR RELIGIOUS AND/OR MORAL BELIEFS ON THEIR FEMALE EMPLOYEES, DEPRIVING THEM OF EQUAL ACCESS TO HEALTH CARE COVERAGE AS THEIR MALE COLLEAGUES

On October 6, 2017, Defendants promulgated sweeping new rules upending women's access to contraceptive coverage in two IFRs, denying the public an opportunity to comment before these drastic changes went into effect. ECF Nos. 24-1 & 24-2. The first IFR, the "Religious Exemption IFR," vastly expands the scope of the religious exemption to the contraceptive-coverage requirement. ECF No. 24-1. An exemption is now available to any employer (regardless of corporate structure or religious affiliation), individual, or even a health insurer with objections to coverage of all or a subset of the contraceptive requirement based on sincerely held religious beliefs. The second IFR, the "Moral Exemption IFR," provides that nearly any employer can avoid providing these benefits and services to their female employees if they have a "moral" objection. Like the Religious Exemption IFR, the Moral Exemption IFR extends to any insurers and individuals.

Significantly, under the new IFRs, no employer needs to certify their religious or moral objection to the contraceptive-coverage requirement; nor do they need to notify the federal government. The accommodation process is now entirely voluntary—employers can make use of the accommodation so that their female employees independently receive their statutorily-entitled

contraceptive coverage through an insurer, or they could simply decide not to, resulting in female employees simply not obtaining this coverage *at all*.

Despite the direct impact on potentially millions of women, prior to promulgating these IFRs, Defendants failed to meet or convene publically with several women's, medical, or public health organizations that promote access to health care.[14] For example, Defendants did not meet with the American Academy of Pediatrics, the American Association of Family Physicians, the National Association of Nurse Practitioners in Women's Health, the National Partnership for Women and Families, or the Planned Parenthood Federation of America, among others. *Id*. Defendants primarily met with organizations like the Heritage Foundation, Church Alliance, and the Ethics & Religious Liberty Commission of the Southern Baptist Convention. *Id*. Further, no comments from women's, medical, or public health organizations—or from ACOG—were mentioned or referenced in the IFRs.

LEGAL STANDARD

To obtain a preliminary injunction, the plaintiff must demonstrate that (1) it "is likely to succeed on the merits," (2) it "is likely to suffer irreparable harm in the absence of preliminary relief," (3) "the balance of equities tips in [its] favor," and (4) "an injunction is in the public interest." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). Courts evaluate these factors on a "'sliding scale approach,' such that serious questions going to the merits and a balance of hardships that tips sharply towards the plaintiff can support issuance of a preliminary injunction, so long as the plaintiff also shows that there is a likelihood of irreparable injury and that the injunction is in the public interest." *Arc of Cal. v. Douglas*, 757 F.3d 975, 983 (9th Cir. 2014) (quoting *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1131, 1135 (9th Cir. 2011)). The States are seeking a nationwide injunction because the IFRs cause harm throughout the country. *Califano v. Yamaski*, 442 U.S. 682, 702 (1979) ("[T]he scope of injunctive relief is dictated by the extent of the violation established, not by the geographical extent of the

[14] Office of Information and Regulatory Affairs, Office of Management and Budget, EO 12866 Meetings, available at https://www.reginfo.gov/public/do/eom12866SearchResults.

plaintiff."); *see also Washington v. Trump*, 847 F.3d 1151, 1166-67 (2017) (affirming nationwide injunction against executive branch travel ban order).

ISSUE TO BE DECIDED

Do the interim final rules, promulgated without notice and opportunity to comment, hinder, rather than advance, the ACA's guarantee to women for no-cost preventive health care and services, violate the APA and the Constitution, and irreparably harm the States and women, necessitating injunctive relief to maintain the status quo?

ARGUMENT

I. THE STATES ARE LIKELY TO SUCCEED ON THE MERITS

A. The IFRs Are Invalid Under the APA Because They Are Not in Accordance with the Law and in Excess of Statutory Authority

The IFRs must be held "unlawful and set aside" because they are "not in accordance with the law" and are "in excess of statutory jurisdiction." 5 U.S.C. §§ 706(2)(A), 706(2)(C). Here, Congress did not delegate to Defendants the ability to promulgate rules that undercut the ACA's protection for women to access no-cost preventive services. *Michigan v. EPA*, 286 F.3d 1075, 1081 (D.C. Cir. 2001) (citing *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988)).

1. The IFRs Are Contrary to Law Because They Violate the Women's Health Amendment

The new IFRs cannot be reconciled with the plain language of the ACA. They are, in fact, contrary to the implementing statute itself, which states that, "a group health plan and a health insurance issuer offering group or individual health insurance coverage *shall*, at a minimum provide coverage for and shall not impose any cost sharing requirements for . . . (4) with respect to *women*, such additional preventive care and screenings . . . ." 42 U.S.C. § 300gg-13(a)(4) (emphasis added). The statute itself makes plain that the "preventive care" relating to "women" "shall" be provided. There is nothing within the statute suggesting that broad categories of employers, plan sponsors, issuers, or individuals can be exempt from this statutory requirement.

Moreover, the IFRs cannot be reconciled with the purpose of the ACA—which seeks to promote access to women's health care, not limit it. The ACA's requirement that group health plans cover women's "preventive care and screenings" (42 U.S.C. § 300gg-13(a)(4)) was added

by the Women's Health Amendment, which was introduced with the express purpose of ensuring that women have equal access to health care and are not required to pay more than men for preventive care, including contraception. *See Hobby Lobby Stores*, 134 S. Ct. at 2788 (Ginsburg, J., dissenting); 158 Cong. Rec. S375 (noting that it is the female employee's decision, not the employer's, whether she chooses to exercise her right to use birth control or access the ACA's preventive health measures, despite the religious affiliation of her employer). Consistent with the legislative history, the Supreme Court has concluded that the government has a compelling government interest in ensuring the health of female employees, including access to contraceptive coverage. *See Hobby Lobby Stores*, 134 S. Ct. at 2785-86 (Kennedy, J., concurring). Defendants' IFRs jettison the government's compelling interest in ensuring women's equal access to health care. While the provision added by the Women's Health Amendment delegates to HRSA the responsibility of setting forth the "comprehensive guidelines," defendants may not exercise that discretion in a manner that effaces the provision's core purpose. *See Michigan v. EPA*, 135 S. Ct. 2699, 2708 (2015) (Chevron deference "does not license interpretive gerrymanders under which an agency keeps parts of statutory context it likes while throwing away parts it does not."). Defendants' implementation of the ACA's directive effaces the provision's core purpose and is therefore invalid under the APA. *See, e.g.*, *Nw. Envtl. Def. Ctr. v. Bonneville Power Admin.*, 477 F.3d 668, 681-86 (9th Cir. 2007) (setting aside agency action where action is contrary to governing law); *see also Phillips Petroleum Co. v. FERC*, 792 F.2d 1165, 1170-71 (D.C. Cir. 1986) (rejecting agency interpretation of statute where agency's position "was based solely on its erroneous reading" of a Supreme Court case and agency "believed itself bound by" that case).

2. The IFRs Are Contrary to Law Because They Exceed What is Required by RFRA, and the ACA Does Not Permit Exemptions Broader than What is Required by RFRA

Defendants' reliance on RFRA to enact these two broad IFRs is misplaced and thus, the IFRs must be set aside. ECF 24-1 at 8-16; *See, e.g.*, *Massachusetts v. EPA*, 549 U.S. 497, 532 (2007); *Chenery I*, 318 U.S. at 94 ("[A]n order may not stand if the agency has misconceived the law."); *Safe Air for Everyone v. EPA*, 488 F.3d 1088, 1101 (9th Cir. 2007); *Humane Soc. of U.S.*

v. Locke, 626 F.3d 1040, 1051 (9th Cir. 2010). RFRA states that the "government shall not substantially burden a person's exercise of religion even if the burden results from a rule of general applicability." 42 U.S.C. § 2000bb-1(a). If the government substantially burdens a person's exercise of religion, under the Act that person is entitled to an exemption from the rule unless the Government "demonstrates that application of the burden to the person – (1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest." 42 U.S.C. § 2000bb-1(b).

With regard to the Moral Exemption IFR, RFRA simply does not apply because RFRA does not extend to moral beliefs. Thus, there is *no* law that authorizes the Moral Exemption IFR, and it is therefore invalid under the APA because it is not in accordance with the ACA.[15]

Even the new Religious Exemption IFR, however, exceeds the bounds of RFRA. As a threshold matter, the Religious Exemption IFR extends the prior narrow exemption for churches and broadens that exemption to publicly-traded corporations; however, "person," as defined in RFRA, does not extend to for-profit publicly-traded corporations. Moreover, RFRA does not give Defendants license to allow employers to deprive women of their statutorily-entitled benefits. To the extent that an employer has a religious objection, in compliance with RFRA, Defendants must still ensure that their female employees are not coerced to participate in the religious beliefs of their employer, such that women are deprived of their equal access to medical care. *See infra* at 21-24 (discussing violation of Establishment Clause because of undue burden to women,

[15] Defendants' reliance on other statutory schemes undercuts Defendants' own arguments, rather than supports it. *See, e.g.*, ECF No. 24-2 at 1 n.1. The fact that in other instances Congress explicitly carved out exemptions for "religious beliefs or moral convictions" in the statute itself demonstrates that Congress knows how to explicitly provide for such exemptions and chose not to do so in passing the ACA. *Nat. Fed. of Independent Business v. Sebelius*, 567 U.S. 519, 544 (2012) (where Congress uses certain language in one statute and different language in another, "it is generally presumed that Congress acts intentionally"). In fact, several amendments were proposed during the ACA's implementation that would have included additional limitations on women's health care coverage, but Congress rejected these amendments. *See* Congressional Record-House H12921 (Nov. 7, 2009) (Stupak-Pitts Amendment); 158 Cong. Rec. S538-S539 (Feb. 9, 2012); 158 Cong. Rec. S1162-S1173 (Mar. 1, 2012). The Supreme Court will "not assume that Congress intended to enact statutory language that it has earlier discarded in favor of other language." *Chickasaw Nation v. U.S.*, 534 U.S. 84, 93 (2001) (internal quotation marks and citations omitted).

excessive entanglement with religious entities, and coercive participation in religious practices of employers). RFRA cannot justify the broad scope of the Religious Exemption IFR.

3. The IFRs Are Contrary to Law Because They Violate Other Provisions within the ACA

The IFRs are also incompatible with other provisions within the ACA. For instance, the ACA itself prohibits discrimination based on sex. 42 U.S.C. § 18116 (2015); *see also Ferrer v. CareFirst, Inc.*, -- F.Supp.3d --, 2017 WL 3025839, *2-3 (D.D.C. 2017) (finding that women had standing to challenge their health care plans' failure to cover breastfeeding support, supplies, and counseling services as a violation of the ACA).[16] And, Section 1554 forbids the Secretary of Health and Human Services from promulgating regulations that block access to health care. 42 U.S.C. § 18114 (2015).[17] The IFRs violate both of these specific statutes by permitting nearly *any* employer to cease providing complete coverage to their female employees without any review of claimed "sincerely held religious beliefs" or "sincerely held moral convictions" prior to withdrawal of or refusal to provide entitled coverage. The IFRs cannot be reconciled with either statute. *See infra* at 25-28 (describing the discriminatory impact on women).

4. The IFRs Must Be Set Aside Because They Are in Excess of Statutory Jurisdiction

Defendants, like other federal agencies, "literally [have] no power to act . . . unless and until Congress confers power upon it." *La. Pub. Serv. Comm'n v. FCC*, 476 U.S. 355, 374 (1986); 5 U.S.C. § 706(2)(C). In determining whether Defendants exceeded their statutory authority, this

[16] The text of section 1557 provides: "Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under . . . title IX of the Education Amendments of 1972, . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments)." 42 U.S.C. § 18116 (2015).

[17] The text of section 1554 provides: "Notwithstanding any other provision of this Act, the Secretary of Health and Human Services shall not promulgate any regulation that—(1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care; (2) impedes timely access to health care services; (3) interferes with communications regarding a full range of treatment options between the patient and the provider; (4) restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions; (5) violates the principles of informed consent and the ethical standards of health care professionals; or (6) limits the availability of health care treatment for the full duration of a patient's medical needs."

Court must undertake a two-step process. *American Library Ass'n v. FCC*, 406 F.3d 689, 698-99 (D.C. Cir. 2005). First, the court must ascertain whether the statute "has directly spoken to the precise question at issue;" if the statute is unambiguously clear, "that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-843 (1984). Second, if the statute admits of some ambiguity, then courts must determine whether the agency's interpretation is "reasonable." *Id*. at 844. In assessing whether an agency's interpretation is "reasonable," courts apply normal canons of statutory construction, and may therefore look not only to the law's text, but to its structure, purpose, and legislative history. A regulation that adopts an interpretation so unreasonable that it directly conflicts with the statute it purports to implement is invalid. *Ragsdale v. Wolverine World Wide, Inc*., 535 U.S. 81, 91-92, 95-96 (2002) (holding agency interpretation unreasonable where it conflicts with the law's "remedial scheme" and Congress's intent).

As discussed above, Defendants did not have the authority under the ACA to enact the IFRs. They are, in fact, contrary to several provisions within the ACA, including the guarantee to women of no-cost preventive care and screenings, the guarantee of nondiscrimination on the basis of sex, and the guarantee that access to health care not be blocked. Defendants' interpretation of the ACA is also unreasonable based on the ACA's text, structure, purpose, and legislative history. *See supra* at 11-14. Thus, the IFRs must be held unlawful and set aside as being in excess of statutory authority. 5 U.S.C. § 706(2)(C).

B. The IFRs Are Invalid Because Defendants Violated the APA by Failing to Provide the Requisite Notice and Comment

Defendants evaded their obligations under the APA by promulgating rules without proper notice and comment. The APA requires agencies to provide the public notice and an opportunity to be heard before promulgating a regulation. The agency must publish in the Federal Register a notice of proposed rulemaking that includes "(1) a statement of the time, place, and nature of public rule making proceedings; (2) reference to the legal authority under which the rule is proposed; and (3) either the terms or substance of the proposed rule or a description of the

subjects and issues involved." 5 U.S.C. § 553(b). After the notice has issued, "the agency shall give interested persons an opportunity to participate in the rulemaking through submission of written data, views, or arguments with or without opportunity for oral presentation." *Id.* § 553(c).

In narrow circumstances, the APA exempts agencies from this notice and comment process where they can show "good cause" that the process would be either "impracticable, unnecessary, or contrary to the public interest." *Id.* § 553(b)(B). The burden is on the agency to demonstrate good cause, and courts have interpreted the exception narrowly. *See, e.g., Lake Carriers' Ass'n v. EPA*, 652 F.3d 1, 6 (D.C. Cir. 2011) (exception "'must be narrowly construed and only reluctantly countenanced'"). An agency's legal conclusion that good cause has been shown is entitled to no deference. *Sorenson Commc'ns, Inc. v. FCC*, 755 F.3d 702, 706 (D.C. Cir. 2014). "Impracticability" is confined to emergency situations that will result in substantial injury absent immediate action. *See Jifry v. FAA*, 370 F.3d 1174, 1179-1180 (D.C. Cir. 2004) (good cause shown where rule necessary to combat the "threat of further terrorist acts involving aircraft in the aftermath of September 11, 2001"); *Hawaii Helicopter Operators Ass'n v. FAA*, 51 F.3d 212, 214-215 (9th Cir. 1995). "Unnecessary" circumstances arise only where the rule effects a minor change or when providing notice and comment could not conceivably produce a different result. *See Lake Carriers' Ass'n*, 652 F.3d at 10 (declining to remand for notice and comment where it would be "futile" and "serve[] no purpose"); *Mack Trucks*, 682 F.3d at 94 (notice and comment is unnecessary where the rule "'is a routine determination, insignificant in nature and impact, and inconsequential to the industry and to the public'"). A rule is "contrary to the public interest" in the unusual circumstance where "'the interest of the public would be defeated by any requirement of advance notice,'" such as when "announcement of a proposed rule would enable the sort of financial manipulation the rule sought to prevent." *Util. Solid Waste Activities Grp. v. EPA*, 236 F.3d 749, 755 (D.C. Cir. 2001); *see also DeRieux v. Five Smiths, Inc.*, 499 F.2d 1321, 1332 (Temp. Emer. Ct. App. 1974).[18]

[18] Defendants concede that the "unnecessary" exception does not apply as neither IFR raises this exception to justify the failure to provide notice and comment. *See* ECF No. 24-2 at 18; ECF No. 24-1 at 23.

Here, it is undisputed that Defendants bypassed the required notice and comment requirements of the APA, and thus it is their burden to demonstrate good cause for such action. Defendants' stated reasons, however, fall far short of meeting the applicable standard. *See* ECF No. 24-2 at 18. For example, the Defendants in the IFRs assert (1) a desire to resolve the lingering litigation left in the wake of *Zubik* (*id.*); (2) the fact that there has been ample public comment on this general topic in past regulations (*id.*); and (3) that past HHS regulations relating to contraceptive care have been promulgated without notice and comment (*id.*). These justifications amount to little more than a desire for expediency, and do not meet the high bar of showing "good cause" under section 553(b)(B).

None of these excuses meet the narrow circumstances of "impractical" or "contrary to the public interest." Defendants have not identified an emergency situation and have not shown that public interest would be defeated by notice. To the contrary, given that the prior regulations generated significant public comment, it is reasonable to assume that these IFRs would also be of considerable public interest, which militates in favor of allowing more public review—not less. *See* ECF No. 24-2 at 18 (recognizing that Defendants received "more than 100,000 public comments on multiple occasions" and most recently received "54,000 comments about different possible ways to resolve these issues"). Similarly, Defendants' stated wish to resolve pending litigation is undercut by the fact that the new IFRs have resulted in significant new litigation, including this lawsuit and similar lawsuits filed by Washington, Massachusetts, Pennsylvania, and individuals in Colorado, Washington, D.C., and Indiana.[19] Moreover, the prior IFRs were promulgated under significantly different circumstances than these IFRs, and, therefore, the fact that in the past IFRs were utilized does not lend support for promulgation of these IFRs. *See Priests For Life v. HHS*, 772 F.3d 229, 276 (D.C. Cir. 2014), *vacated on other grounds and*

[19] *See State of Wash. v. Trump, et al.*, Case No. 2:17-cv-1510, U.S. District Court-Western District of Wash.; *Commonwealth of Mass. v. U.S. Dept. of Health & Human Services, et al.*, Case No. 1:17-cv-11930, U.S. District Court-Mass.; *Commonwealth of Pa. v. Trump, et al.*, Case No. 2:17-cv-4540, U.S. District Court-Eastern District of Pa.; *Campbell v. Trump, et al.*, Case No. 1:17-cv-2455, U.S. District Court-Colorado; *Medical Students for Choice et al. v. Wright, et al.*, Case No. 1:17-cv-2096, U.S. District Court-District of Columbia; *Shiraef v. Hargan, et al.*, Case No. 3:17-cv-00817, U.S. District Court-Northern District of Indiana.

remanded sub nom Zubik v. Burwell, 136 S. Ct. 1557 (2016) (noting that rule effects "minor" changes to the current regime).

Nor do Defendants have specific statutory authority to issue these IFRs without notice and comment. Aside from demonstrating good cause, agencies are excused from the notice and comment requirement only "when a subsequent statute 'plainly expresses a congressional intent to depart from normal APA procedures.'" *Lake Carriers' Ass'n*, 652 F.3d at 6 (citation omitted); *see also* 5 U.S.C. § 559 (a "[s]ubsequent statute may not be held to supersede or modify this subchapter . . . except to the extent it does so expressly"). Here, Defendants rely on a series of statutes in an effort to excuse failing to meet the APA's notice and comment requirement (*see* ECF Nos. 24-2 at 17-18; 24-1 at 22)[20]; however, these statutes were enacted prior to the ACA, and thus, do not announce Congressional intent to excuse Defendants' compliance with the APA. Furthermore, even if these statutes did apply to the ACA, "[t]he statutory provisions authorizing interim final rules in this case do not mention notice and comment or any other aspect of the APA." *Coalition for Parity, Inc. v. Sebelius*, 709 F. Supp. 2d 10, 18 (D.D.C. 2010) (concluding that 42 U.S.C. § 300gg-92 does not constitute an exemption from the APA). The statutes "may be read to require that interim final rules be promulgated either with notice and comment or with 'good cause' to forgo notice and comment." *Id.* at 19. Thus, the statutes do not "plainly express[] a congressional intent to depart from normal APA procedures." *Lake Carriers' Ass'n*, 652 F.3d at 6.

Defendants have not demonstrated and cannot demonstrate good cause for failing to give any notice to the public or allowing for public comment before these rules took immediate effect. Notice and comment is particularly important in legally and factually complex circumstances like those presented here. Notice and comment allows affected parties—including States—to explain the practical effects of a rule before it's implemented, and ensures that the agency proceeds in a

[20] Defendants reference 26 U.S.C. § 9833 (section 9833 of the Internal Revenue Code), 29 U.S.C. § 1191c (section 734 of ERISA), 42 U.S.C. § 300gg-92 (section 2792 of the Public Health Service Act of 1996). Notably, Defendants do not rely on any statutory provision of the ACA itself.

fully informed manner, exploring alternative, less harmful approaches. Because Defendants failed to follow section 553's notice and comment procedures, the IFRs are invalid.

C. The IFRs Are Arbitrary and Capricious Because Defendants Failed to Provide an Adequate Justification and Therefore They Are Invalid Under the APA

The IFRs are arbitrary and capricious because they constitute a complete reversal of prior agency policy and yet, Defendants fail to articulate a detailed justification for such a substantial shift. Under the APA, a court may invalidate a regulation that is "arbitrary" or "capricious." 5 U.S.C. § 706(2)(A). The agency must "articulate a 'rational connection between the facts found and the choice made.'" *Bowman Transp., Inc. v. Arkansas-Best Freight Sys., Inc.*, 419 U.S. 281, 285 (1974); *see also* 5 U.S.C. 553(c) (agency must provide a "concise general statement of [a regulation's] basis or purpose"). "[A]n agency's action must be upheld, if at all, on the basis articulated by the agency itself." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 50 (1983).

An agency departing from a prior policy must at a minimum "demonstrate awareness that it is changing position." *F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009); *Jicarilla Apache Nation v. U.S. Dept. of Interior*, 613 F.3d at 1112, 1119 (D.C. Cir. 2010) (Where government reverses an earlier policy determination, "[r]easoned decision making necessarily requires [an] agency to acknowledge and provide an adequate explanation for its departure from established precedent and an agency that neglects to do so acts arbitrarily and capriciously"). A more "detailed justification" is necessary where there are "serious reliance interests" at stake or the new policy "rests upon factual findings that contradict those which underlay its prior policy." *F.C.C.*, 556 U.S. at 515; *see also State Farm*, 463 U.S. at 48-51 (regulation rescinding prior regulation after change in presidential administration was arbitrary and capricious where agency failed to address prior fact findings); *Decker v. Nw. Environmental Defense Ctr.*, 568 U.S. 597, 614 (2013). Thus, the government must provide still greater justification for the reversal "when its policy has engendered serious reliance interests that must be taken into account." *Perez v. Mortgage Bankers Ass'n*, 135 S. Ct. 1199, 1209 (2015). The fact of a change in administration does not authorize an unreasoned reversal of course. *See State v. U.S. Bureau of Land Mgmt.*, --

F.Supp.3d. --, 2017 WL 4416409, at *11 (N.D. Cal. 2017) ("New presidential administrations are entitled to change policy positions, but to meet the requirements of the APA, they must give reasoned explanations for those changes and address the prior factual findings underpinning a prior regulatory regime." (quotation marks and brackets omitted)).

Here, the IFRs effect a significant change in policy, which, if not an outright repeal of the ACA's guarantee of women's access to no-cost contraceptive coverage, could impact over half of the U.S. population. To survive scrutiny under section 706(2)(A), Defendants must provide adequate explanation for the new policy, despite the factual record remaining unchanged since the prior regulations were promulgated. The IFRs cite a number of reasons for the change, none of which meet this heightened standard, given the number of women relying on the prior rules.

For instance, the prior regulations found a compelling government interest in ensuring that women have access to contraceptive coverage, and this position was supported by the Supreme Court. *Hobby Lobby Stores*, 134 S. Ct. at 2785-86 (Kennedy, J., concurring). The new IFRs announce that there is not a compelling interest in ensuring women's access to contraceptive coverage. ECF No. 24-1 at 9-15. The rules provide no support for this complete about-face reversal. The IFRs also ignore other public health interests, such as the use of contraceptive medicines for non-birth control purposes. Lawrence Decl. ¶ 5; Bates Decl. ¶ 3. Defendants fail to justify the expanding universe of employers, or its extension of the exemption (as opposed to the accommodation). The IFRs refer to the *Hobby Lobby* and *Zubik* decisions, yet the Supreme Court has never suggested that such a broad exemption, encompassing religious and moral objections for nearly any employer, is necessary. And the IFRs rely on information about women's health that is "unfounded and ignore[s] rigorous research findings." Finer Decl. ¶ 20. The agencies' interpretations of RFRA are entitled to no deference; indeed, even RFRA does not support the agencies' position (*see supra* at 13-14).

The new IFRs note that contraceptive coverage is not mandated by Congress, only by the implementing regulations. ECF Nos. 24-1 at 9-10; 24-2 at 1-2. Yet, the HRSA guidelines explicitly cited in the ACA detailed that preventive services include that all FDA-approved contraceptive methods be provided without cost-sharing (along with other critical preventive

services for women). The legislative history of the Women's Health Amendment further demonstrates that Congress expected contraceptives to fall within its ambit. Although the new IFRs attack certain aspects of an expert report on contraceptive coverage issued by the IOM, Defendants conveniently ignore the report's core findings that providing no-cost coverage of the full range of contraceptives is critical to women's health and wellbeing. ECF No. 24-2 at 4. The new IFRs state that other federal and state programs already provide women access to contraception, but this was true when the contraceptive-coverage requirement was promulgated. ECF Nos. 24-1 at 12; 24-2 at 1, 17. Further, these programs "simply cannot replicate or replace the gains in access made by the contraceptive coverage guarantee." Finer Decl. ¶ 47.

In short, the new IFRs are "arbitrary" or "capricious" and therefore invalid. 5 U.S.C. § 706(2)(A). Although the facts have remained relatively unchanged since the prior regulations were promulgated, Defendants have made a significant change in policy in promulgating the new IFRs. These changes are not supported by any new factual developments. As such, Defendants have acted arbitrarily and capriciously and the IFRs should be found unlawful. *See Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126 (2016) (declining to defer to agency where it demonstrated awareness it was changing policy but provided insufficiently reasoned explanation for "why it deemed it necessary to overrule its previous position."); *see also F.C.C.*, 556 U.S. at 535-536 (Kennedy, J., concurring).

D. The IFRs Violate the Establishment Clause[21]

The IFRs violate the Establishment Clause because they have a significant religious purpose, they substantially burden women with the religious accommodations of their employer and foster excessive government entanglement with religion because they vest nongovernmental entities (employers) with the ability to eliminate benefits guaranteed by federal law.

[21] Because the States' APA claims demonstrate that a preliminary injunction should issue, this Court need not even reach the Constitutional claims. *See In re Ozenne*, 841 F.3d 810, 814-15 (9th Cir. 2016) ("as a fundamental rule of judicial restraint, [the court] must consider nonconstitutional grounds for decision before reaching any constitutional questions" (internal quotation marks and citations omitted)).

The First Amendment provides that "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof." U.S. Const., amend. I. "The clearest command of the Establishment Clause is that one religious denomination cannot be officially preferred over another," or over no religion at all. *Larson v. Valente*, 456 U.S. 228, 244 (1982); *see also Kiryas Joel Village Sch. Dist. v. Grument*, 512 U.S. 687, 703 (1994) ("government should not prefer one religion to another, or religion to irreligion"). "A statute or regulation will survive an Establishment Clause attack if (1) it has a secular legislative purpose, (2) its primary effect neither advances nor inhibits religion, and (3) it does not foster excessive government entanglement with religion." *Williams v. California*, 764 F.3d 1002, 1014 (9th Cir. 2014) (citing *Lemon v. Kurtzman*, 403 U.S. 602, 612-13 (1971)). If any of these three requirements of the *Lemon* test are not met, the government action violates the Establishment Clause. Here, the IFRs fail all three prongs.

First, the Religious Exemption IFR has a wholly religious purpose. *See American Family Ass'n, Inc. v. City & County of San Francisco*, 277 F.3d 1114, 1121 (9th Cir. 2002); *Corp. of Presiding Bishop of Church of Jesus Christ of Latter-day Saints v. Amos*, 483 U.S. 327, 335 (1987) (the secular purpose requirement "aims at preventing the relevant governmental decisionmaker…from abandoning neutrality and acting with the intent of promoting a particular point of view in religious matters."). Aside from their facial support for religion, the fact that Defendants met primarily with religious organizations before promulgating the IFRs and did not meet with women's or health care organizations further demonstrates Defendants' purpose. The IFRs themselves are permeated with analysis and commentary on religion without significant regard for the compelling interest of women's health care. This pervasive focus on religious beliefs establishes it as the primary basis for issuing the IFRs. *See, e.g., Edwards*, 482 U.S. at 590 (finding that the Louisiana Legislature had "preeminent religious purpose" in enacting statute forbidding the teaching of evolution in public schools unless accompanied by instruction in "creation science"). These facts resoundingly demonstrate that the IFRs have a religious purpose, to the detriment of millions of women.

Second, the principal effect of the IFRs is to advance certain religious beliefs of employers. The IFRs violate the second prong of the *Lemon* test by accommodating employers' religious beliefs to such an extent that it places an undue burden on third parties. In *Estate of Thornton v. Caldor*, 472 U.S. 703 (1985), the Court invalidated a law providing employees with the absolute right to not work on their chosen Sabbath because the law unfairly burdened the employers and fellow employees who did not share the employee's faith. "The First Amendment ... gives no one the right to insist that in pursuit of their own interests others must conform their conduct to his own religious necessities." *Id*. at 710 (quoting *Otten v. Baltimore & Ohio R.R. Co*., 205 F.2d 58, 61 (1953)). The Court found the law invalid under the Establishment Clause because it "unyielding[ly] weight[ed]" the interests of Sabbatarians "over all other interests." *Id*.

The IFRs here substantially burden third parties—female employees (and the female dependents of all employees) by denying them access to preventive care and services—based on the religious beliefs of the employer. Because the IFRs are not narrowly tailored and ignore the compelling interest of seamless access to contraceptive coverage for women, they cross the line from acceptable accommodation to religious endorsement prohibited by the second prong of *Lemon*. *See Hobby Lobby Stores*, 134 S. Ct. at 2785-2486 (Kennedy, J., concurring) (confirming that the premise of the majority's decision is that the federal government has a legitimate and compelling interest in ensuring the health of female employees, including access to contraceptive coverage). The Supreme Court has cautioned that "adequate account must be taken" of "the burdens a requested accommodation may impose on nonbeneficiaries." *See Cutter v. Wilkinson*, 544 U.S. 709, 720 (2005); *id*. at 722 ("an accommodation must be measured so that it does not override other significant interests"); *see also Santa Fe Independent School Dist. v. Doe*, 530 U.S. 290 (2000) (holding unconstitutional student-initiated and student-led prayer at school football games); *Lee v. Weisman*, 505 U.S. 557 (1992) (holding unlawful officially sponsored graduation prayers).[22]

[22] These same issues arise with regard to Defendants' Moral Exemption IFR. The Moral Exemption IFR states that it is necessary to "protect[] moral convictions alongside religious beliefs." ECF No. 24-2 at 7, 2, 1, 10. This demonstrates that the Moral Exemption IFR is merely a corollary of the Religious Exemption IFR and should be considered together with it. In fact, the (continued…)

Lastly, the IFRs foster "an excessive government entanglement with religion." *Lemon*, 403 U.S. at 612-13. "In determining whether there is an excessive entanglement with religion, [the court] must analyze 'the character and purpose of the institutions that are benefitted, the nature of the aid that the [government] provides, and the resulting relationships between the government and religious activity.'" *Williams*, 764 F.3d at 1015 (quoting *Lemon*, 403 U.S. at 615). "A relationship results in an excessive entanglement with religion if it requires 'sustained and detailed' interaction between church and State 'for enforcement of statutory or administrative standards.'" *Id*. (quoting *Lemon*, 403 U.S. at 621). The IFRs ensure "excessive entanglement" because the IFRs effectively vest nongovernmental entities with the power to eliminate certain benefits and services otherwise guaranteed by federal law to female employees. *Larkin*, 459 U.S. at 122-27 (statute which vests churches with power to veto liquor licenses violates Establishment Clause). "The Framers did not set up a system of government in which important, discretionary governmental powers would be delegated to or shared with religious institutions." *Id*. at 127 (rationale of Establishment Clause is preventing a fusion of governmental and religious functions). The IFRs enmesh religious or moral objectors in the exercise of substantial governmental power – providing health care benefits and services. *Id*. at 126. Such a system violates the "excessive entanglement" prong of *Lemon*.[23]

(…continued)
Moral Exemption IFR allows the religious purpose to be carried out far beyond the legitimate religious objections. The Supreme Court has invalidated laws that privilege religious institutions, even if they extend that privilege to non-religious institutions. *See Larkin v. Grendel's Den*, 459 U.S. 116 (1982) (zoning law prohibiting liquor licenses to businesses near schools and churches violates Establishment Clause).

[23] Aside from the *Lemon* test, the Supreme Court has used several other matrices to test whether a law violates the Establishment Clause. For instance, the Court has used the "coercion" test. *Allegheny County v. ACLU*, 492 U.S. 573, 659-60 (1989) (Kennedy, J., concurring in judgment in part and dissenting in part) (abrogated in part by *Town of Greece, N.Y. v. Galloway*, 134 S. Ct. 1811 (2014)); *see also Van Orden v. Perry*, 545 U.S. 677, 683 (2005) (plurality opinion) (recognizing that "institutions must not press religious observances upon their citizens"). Under the coercion test, the government violates the Establishment Clause if it coerces people to support or participate in religion against their will. *Id*. at 659, 664; *Lee v. Weisman*, 505 U.S. 577 (1992) (discussing coercive religious activity in public schools). Here, the IFRs are "coercive" because they coerce female employees to support and participate in their employer's religious beliefs against their will because, practically speaking, the employees must adopt their employer's objection, as they lose the health care services they desire (and are entitled to). See Decl. of Susan Russell [Russell Decl.] ¶ 5. When an employer seeks an exemption based on its (continued…)

E. The IFRs Violate the Equal Protection Clause

The Equal Protection Clause of the Fifth Amendment prohibits the federal government from denying equal protection of the laws. Although the ACA requires coverage for many different types of preventive services, the IFRs single out only women's health benefits and services. The IFRs discriminate against women, who are the primary recipients and beneficiaries of contraceptive coverage. Contraceptive coverage is a necessary component of equality between men and women because it allows women to control their health, education and livelihoods. Finer Decl. ¶ 45. Denying women access to this coverage denies them equal opportunity to aspire, achieve, participate in and contribute to society based on their individual talents and capabilities. *Id.* (2011 study found that a majority of women reported that access to contraception had enabled them to take better care of their families (63%), support themselves financially (56%), stay in school or complete their education (51%), or get or keep a job or pursue a career (50%)). Indeed, even the U.S. Supreme Court has concluded that the government has a compelling interest in ensuring women equal access to health care coverage as their male colleagues. *See Hobby Lobby Stores*, 134 S. Ct. at 2785-2786 (Kennedy, J., concurring).

Because the IFRs single out women's health care coverage, thereby creating a gender classification, Defendants must demonstrate an "exceedingly persuasive justification" for the IFRs. *United States v. Virginia*, 518 U.S. 515, 531 (1996); *Miss. Univ. for Women v. Hogan*, 458 U.S. 718, 724 (1982). The Supreme Court has "repeatedly recognized that neither federal nor state government acts compatibly with the equal protection principle when a law . . . denies to women, simply because they are women, full citizenship stature-equal opportunity to aspire, achieve, participate in and contribute to society based on individual talents and capacities." *Virginia*, 518 U.S. at 532 (court must "carefully inspect[] official act that closes a door or denies opportunity to women"). In such instances, the government must meet a "demanding" and

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(…continued)
religious beliefs, its female employee has no ability to obtain her otherwise entitled benefits; she is forced to select a health plan that has been catered to her employer's religious beliefs, without regard to her own beliefs. *Town of Greece*, 134 S.Ct. at 1826 (coercion exists where entity directs non-willing individual to participate in religious activities).

heightened standard of review. *Id*. at 533. The government must show "at least that the [challenged] classification serves important government objectives and that the discriminatory means employed are substantially related to the achievement of those objectives.'" *Sessions v. Morales-Santana*, 137 S. Ct. 1678, 1690 (2017); *see also Nevada Dept. of Human Resources v. Hibbs*, 538 U.S. 721, 728-29 (2003) (heightened scrutiny analysis requires that the government's justification not rely on overbroad generalizations about women).

Defendants cannot meet this rigorous standard. First, the IFRs do not serve an important government interest. The Moral Exemption IFR is purportedly needed to ensure that non-religious entities can exercise their "moral objections" to providing women's health care services. As support for such a rule, Defendants cite only three employers: two who filed suit against the prior regulatory scheme (March for Life and Real Alternatives, Inc.) and one who submitted a comment letter (Americans United for Life). ECF No. 24-2 at 18 & 4 n.10. The requests from these three lone employers and Defendants' desire to accommodate them based on their unsupported assumptions does not amount to an "important" government interest such that it supersedes the rights of millions of women. *See, e.g.*, *Virginia*, 518 U.S. at 541-42, 550.[24] Nor can Defendants demonstrate an "important government interest" to support their Religious Exemption IFR. This IFR's vast expansion to publicly-traded companies and insurers, while simultaneously eliminating the accommodation process, is without justification in the ACA or RFRA. The reasons outlined within the IFR for such an expansion are likewise unsupported.

Second, even if Defendants could demonstrate an important government interest, Defendants cannot demonstrate that the "means employed" are "substantially related" to the

[24] To the extent Defendants rely on historical letters penned by the Founding Fathers to religious organizations, the Supreme Court has repeatedly recognized that in considering a gender discrimination case, the Court must bear in mind that "[o]ur nation has had a long and unfortunate history of sex discrimination." *Virginia*, 518 U.S. at 531 (explaining that women did not count among "We the People" and even after gaining the right to vote, the government could "withhold from women opportunities accorded men" for any reason); *Hibbs*, 538 U.S. at 729. As Justice Kennedy explained, "The nature of injustice is that we may not always see it in our times. The generations that wrote and ratified the Bill of Rights and Fourteenth Amendment did not presume to know the extent of freedom in all of its dimensions and so they entrusted future generations a charter protecting the right of all persons to enjoy liberty as we learn its meaning." *Obergefell v. Hodges*, 135 S. Ct. 2584, 2598 (2015). Thus, reliance on these historical letters cannot justify the IFRs' vast expansion to accommodate moral objections to the detriment of millions of women.

purported "important government interest." *Sessions*, 137 S. Ct. at 1690. Defendants have undertaken several actions that severely limit women's ability to access their statutorily-entitled health care benefits and services, without showing that such actions are substantially related to achieve Defendants' purported important goals. *See, e.g., Orr v. Orr*, 440 U.S. 268, 280-81 (1979) (classification did not substantially relate to objectives where it was gratuitous in that there was a feasible solution, with little additional burden on the State that would eliminate discrimination and would still achieve the government's objectives). Defendants have (1) vastly expanded the exemption to include (a) religious objections of *all* employers, including publicly-traded for-profit corporations; and (b) moral objections of nearly all employers and (2) eliminated the prior safety net that ensured that women would obtain their statutorily-entitled benefits and services, even if their employer exercised its objection. These IFRs and the new process outlined therein fails the "means test" because they are much broader than necessary to achieve any purported goal with respect to accommodating employers, and fail to account for the compelling interest of providing health care to women.

In the event that this Court concludes that the IFRs do not facially discriminate against women, the IFRs are still unconstitutional because they are both overtly and covertly discriminatory and have a discriminatory impact on women. *Personnel Adm'r of Mass. v. Feeney*, 442 U.S. 256, 273-74 (1979) (*Feeney*); *Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 265-68 (1977); *accord Arce v. Douglas*, 793 F.3d 968, 977 (9th Cir. 2015). The IFRs are overtly discriminatory because they single out women's health care services, including benefits that are only used by women. *See, e.g.*, ECF No. 24-1 at 3, 26 (discussing different methods of contraceptive coverage used exclusively by women). Aside from the reference to only women's services, the IFRs are infused with overt reference to purported "sensitive" areas of health, which all concern *women's* reproductive health and rely on overly-broad generalizations of women's health care. ECF No. 24-2 at 1, 7, 12-14. The IFRs are covertly discriminatory because they have a direct impact on women.[25] Finer Decl. ¶¶ 38-46 (describing harms to women

[25] Although the government argues that expanding the exemption will not impose any real harm, this argument is misleading. Finer Decl. ¶ 46 ("Low-income women, women of color and (continued…)

as a result of the IFRs, including unintended pregnancies, being unable to space and time pregnancies, and affecting the overall health of women) and ¶ 42 (isolating contraceptive coverage in this way interferes with the ability of health care providers to treat women holistically); Decl. of Jenna Tosh [Tosh Decl.] at 11-12. Women will be forced to struggle to pay for it themselves, forgo contraceptive coverage, or switch to less expensive contraceptives that may be less effective for them, risking an unintended pregnancy, or to try to seek out services from some entity other than their employer. Finer ¶ 54. These harms uniquely impact women in that they affect women's ability to pursue additional education, spend additional time in their careers, and have increased earning power over the long term. Tosh Decl. at 9; Arensmeyer Decl. ¶ 4 (findings from a nationwide survey of women small business owners show that "56 percent of respondents agree that birth control access was beneficial for their own individual pursuit of education and business ownership."); Bates Decl. ¶¶ 3, 6. The IFRs' exemptions give no weight to the substantial, compelling interest in protecting women's health by providing contraceptive coverage under the ACA. Nor are they consistent with previous findings by Defendants, the research that supported those findings, and the views of the U.S. Supreme Court. *See Hobby Lobby Stores*, 134 S. Ct. at 2785-2486 (Kennedy, J., concurring).

II. ABSENT AN INJUNCTION, THE STATES WILL SUFFER IRREPARABLE HARM

The IFRs are likely to inflict irreparable harm upon the States. *Winter*, 555 U.S. at 22. A likelihood of violating constitutional rights is alone enough to show irreparable harm. *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012) ("It is well established that the deprivation of constitutional rights 'unquestionably constitutes irreparable injury'") (quoting *Elrod v. Burns*, 427 U.S. 347, 373 (1976)); *cf. Latta v. Otter*, 771 F.3d 496, 500 (9th Cir. 2014) (to deny gay couples the constitutional right to marry would cause irreparable harm).[26] In addition to the trampling of

(…continued)
women aged 18-24 are at disproportionately high risk for unintended pregnancy, and millions of these women rely on private insurance coverage—particularly following implementation of the ACA").

[26] Indeed, in suggesting that the Moral Exemption IFR should take effect immediately because the former ACA regulations purportedly violate equal protection rights, Defendants concede that it is an "urgent matter" when an entity suffers a constitutional injury because such injury "cannot be repaired retroactively." *See* ECF No. 1-2 at 67.

constitutional rights, the States are subject to actionable harm when "depriv[ed] of a procedural protection to which [they] are entitled" under the APA, including the opportunity to shape the rules through notice and comment. *Northern Mariana Islands v. United States*, 686 F.Supp.2d 7, 17, 18 (D.D.C. 2009) (citing *Sugar Cane Growers Cooperative of Florida v. Veneman*, 289 F.3d 89, 94-95 (D.C. Cir. 2002)).

The threat of harm here is imminent. *Caribbean Marine Servs. Co., Inc. v. Baldrige*, 844 F.2d 668, 674 (9th Cir. 1988). Every day the IFRs are in effect is another day that employers can eliminate contraceptive coverage for employees and their dependents. *See, e.g.*, Decl. of Jonathan Werberg [Werberg Decl.] ¶¶ 4-9. Except as prohibited by the States' Contraceptive Equity Acts applicable to state-regulated insurers, the IFRs permit a new or established business that starts offering health insurance to exempt itself from providing contraceptive coverage without any notice to its workers. For workers and beneficiaries in existing health plans, contraceptive coverage could be dropped as soon as (1) an employer gives 30-days notice that it is revoking its use of the ACA's accommodation process, (2) an employer gives 60-days notice of this material change in benefits, or (3) a new plan year begins on January 1, 2018. ECF No. 24-1 at 38; 26 C.F.R. § 54.9815-2713AT(a)(5); 29 C.F.R. § 2590.715-2713A(a)(5); 45 C.F.R. § 147.131(c)(4); 26 C.F.R. § 54.9815-2715(b); 29 C.F.R. § 2590.715-2715(b); 45 C.F.R. § 147.200(b). This loss of coverage will not only harm women employees and their covered beneficiaries; the States will also suffer concrete and irreparable injury.

First, lack of access to contraception will likely cause unintended pregnancies to rise, triggering a chain of events with widespread repercussions. When contraception is provided at no cost—as is the law under the ACA—women are free to use the most effective methods, resulting in lower rates of unintended pregnancy, abortion, and birth among adolescents. Finer Decl. ¶¶ 7-9, 14-15, 17-19, 32; Lawrence Decl. ¶ 9; Grossman Decl. ¶ 9 ("women now save an average of 20% annually in out-of-pocket expenses, including $248 savings for IUDs and $255 for the contraceptive pill"); Decl. of Lisa Ikemoto [Ikemoto Decl.] ¶ 5; Tosh Decl. ¶ 26; Decl. of Karen Nelson [Nelson Decl.] ¶¶ 21, 30. The converse is true under the IFRs. When the cost of contraception increases, women are more likely to use less effective methods of contraception,

use them inconsistently or incorrectly, or not use them at all—and the result is a higher rate of unintended pregnancies. Finer Decl. ¶¶ 28, 38-43; Lawrence Decl. ¶ 9; Grossman Decl. ¶¶ 8-9 ("women from advantaged groups (income over $75,000) were far more likely to actually use a LARC [long-acting reversible contraceptive] method when they preferred LARC"); Ikemoto Decl. ¶ 5; Decl. of Dave Jones [Jones Decl.] ¶ 15; Tosh Decl. ¶ 35; Nelson Decl. ¶ 30; Decl. of Dr. Karyl Rattay [Rattay Decl.] ¶ 6; Decl. of Ruth Lytle-Barnaby [Lytle-Barnaby Decl.] ¶ 28. Significantly, the risk of unintended pregnancy is greatest for the most vulnerable women: young, low-income, minority women, without high school or college education.[27] Finer Decl. ¶ 46.

The consequences of unintended pregnancies felt by the States and their residents are both immediate and far-reaching. Over half of unintended pregnancies end in miscarriage or abortion. Tosh Decl. ¶ 26. For pregnancies carried to term, intervals between pregnancies of less than eighteen months are associated with poor obstetric outcomes, including maternal health problems, premature birth, birth defects, low birth weight, and low mental and physical functioning in early childhood. Lawrence Decl. ¶ 8; Grossman Decl. ¶ 7. All of these outcomes—whether miscarriages, abortions, or live births (particularly high-risk births)—cost the States in the short-term and long-term. Indeed, the States are burdened not only with funding a significant portion of the medical procedures associated with unintended pregnancies and their aftermath, Finer Decl. ¶¶ 54, 61 (California), 69 (Delaware), 77 (Maryland), 85 (New York), 93 (Virginia); Tosh Decl. ¶¶ 26-28; Rattay Decl. ¶ 5, but also with the costs of lost opportunities for affected women to achieve in education and the workplace and to contribute as taxpayers. Finer Decl. ¶ 45; Lawrence Decl. ¶ 5; Arensmeyer Decl. ¶ 4; Nelson Decl. ¶ 31; Decl. of Keisha Bates [Bates Decl.] ¶¶ 3, 6. These lifelong consequences for women and their families are severe; for the States, such harm is irreparable because it cannot be undone with a successful result at the end of the litigation. The only way to avoid this disruption is to ensure that the ACA's guarantee of no-cost contraceptive coverage is maintained while this litigation proceeds. *Leigh v. Salazar*, 677

[27] IOM Report at 103.

F.3d 892, 902 (9th Cir. 2012) ("Preliminary injunctions normally serve to prevent irreparable harm by preserving the status quo pending a trial or other determination of the action on the merits").

Second, if the IFRs are not enjoined, the States are likely to face increased costs of providing contraception to their residents. This is particularly true in Virginia, which does not have a contraceptive equity law. Decl. of Massey Whorley [Whorley Decl.] ¶ 8. Unlike other states, where the effect of the IFRs is limited to patients covered under self-insured plans, Nelson Decl. ¶ 12, in Virginia there is no state requirement that insurance plans provide no-cost contraceptive coverage. Whorley Decl. ¶ 8. Many women who lose coverage in Virginia will turn to Plan First, Virginia's limited benefit family planning program, which provides contraceptive coverage for women in families below 200 percent of the federal poverty level. *Id.* at ¶¶ 3, 4, 10. The increase in Plan First enrollees—and in women seeking services from hospital systems that are Plan First providers—will cause fiscal harm to Virginia. *Id.* at ¶¶ 10, 11.

Although Virginia and other states like it will be particularly impacted, all states will face rising costs. For example, in California, women (and men) are eligible to enroll in the state's Family Planning, Access, Care, and Treatment (Family PACT) program if they have a family income at or below 200 percent of the federal poverty level, no other source of family planning coverage, and a medical necessity for family planning services. Decl. of Mari Cantwell [Cantwell Decl.] ¶ 7; Tosh Decl. ¶¶ 23, 29. Women who meet these criteria are likely to seek services from Family PACT when their employers slash coverage for contraception from the benefits of self-funded plans. Cantwell Decl. ¶¶ 15, 16; Tosh Decl. ¶ 34. The same goes for New York, Maryland, and Delaware, which all have state family planning programs. Finer Decl. ¶ 63-86. The government—including the States—will be left to pick up the tab.[28] Cantwell Decl. ¶

[28] Another example is Maryland. There, the Medicaid Family Planning Waiver program provides contraceptive coverage to women up to 200 percent of the federal poverty level. In fiscal year 2016, the average monthly enrollment was 12,852 individuals. Women in low-income jobs whose employers choose exemption from contraceptive coverage may qualify for this program, thereby shifting the costs of contraceptives for these women to the State of Maryland. Nelson Decl. ¶¶ 22-25. In addition, Maryland's Medicaid and Children's Health Insurance Plans (MCHP) provide coverage for women up to 138 percent of the federal poverty level and children to 300 percent of the federal poverty level. Eligible women whose employers avail themselves of (continued…)

17; Tosh Decl. ¶ 34; Nelson Decl. ¶ 15; Rattay Decl. ¶ 7. Even a slight uptick in such costs will cause irreparable harm to the States. *Simula, Inc. v. Autoliv, Inc.*, 175 F.3d 716, 724 (9th Cir. 1999) ("magnitude of the injury" is not a determinative factor in the analysis of irreparable harm); *Ariz. Dream Act Coal. v. Brewer*, 757 F.3d 1053, 1068 (9th Cir. 2014) ("the district court erred by attempting to evaluate the severity of the harm to Plaintiffs, rather than simply determining whether the harm to Plaintiffs was irreparable").

III. THE BALANCE OF EQUITIES AND THE PUBLIC INTEREST FAVOR ISSUING AN INJUNCTION TO PRESERVE THE STATUS QUO

For many of the same reasons that the IFRs cause irreparable harm to the States, the balance of the equities and the public interest support issuing a preliminary injunction. *See Winter*, 555 U.S. at 24 (relative hardships to the parties and the public interest must be considered to ensure that minimal harm results from the decision to grant or deny an injunction). Because both parties are government entities, the balancing merges with consideration of the public interest. *Drakes Bay Oyster Co. v. Jewell*, 747 F.3d 1073, 1092 (9th Cir. 2014) (citing *Nken v. Holder*, 556 U.S. 418, 435 (2009)). Thus, the States address these factors together.

As with the analysis of irreparable harm, the balance of the equities and the public interest favor "preventing the violation of a party's constitutional rights." *Ariz. Dream Act Coal. v. Brewer*, 757 F.3d at 1069 (quoting *Melendres*, 695 F.3d at 1002) (brackets omitted). Given that the States have shown a likelihood that the IFRs are unconstitutional, these factors bolster the case for a preliminary injunction. *Id.* So too does Defendants' failure to provide opportunity for notice and comment, because "[t]he public interest is served when administrative agencies comply with their obligations under the APA." *Northern Mariana Islands v. United States*, 686 F.Supp.2d at 21.

When weighing these factors, particular attention should be given to preserving the status quo. *Chalk v. U.S. Dist. Court Cent. Dist. Cal.*, 840 F.2d 701, 704 (9th Cir. 1988) ("The basic

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this broad exemption may turn to these programs for contraceptive coverage for themselves and/or their preteen and teenage children, thereby shifting the costs of their care to the State of Maryland. Nelson Decl. ¶¶ 26-28.

function of a preliminary injunction is to preserve the status quo pending a determination of the action on the merits"). Here, the status quo is the ACA's contraceptive-coverage requirement, as well as the carefully and deliberately crafted accommodations and exemptions to that requirement. *Dep't of Parks & Recreation for State of Cal. v. Bazaar Del Mundo Inc.*, 448 F.3d 1118, 1124 (9th Cir. 2006) (status quo is "the last uncontested status that preceded the parties' controversy"). The IFRs disturb the delicate balance struck by the former ACA regulations.

While the immediate enforcement of the IFRs will inflict grave and lasting harm upon the States and their residents, Defendants will suffer little if any harm if the IFRs are enjoined. Defendants acknowledge as much; their main justification for rushing the IFRs into effect without full vetting is to avoid "delay [in] the ability of organizations and individuals to avail themselves of the relief by these interim rules." ECF No. 24-1 at 23. Yet a delay in the IFRs' implementation would have little effect on Defendants, given that the ACA's accommodations and exemptions would still be available as this matter is litigated to its conclusion. *League of Wilderness Defenders/Blue Mountains Biodiversity Project. v. Connaughton*, 752 F.3d 755, 765 (9th Cir. 2014) (the balance of equities generally tips in favor of plaintiffs when the harms they face if an injunction is denied are permanent, while the harms defendants face if an injunction is granted are temporary). And because no-cost contraceptive coverage has significant public health benefits, *supra*, at 3, 30, the public interest strongly favors enjoining the IFRs—which undermine these benefits—and maintaining the status quo.

CONCLUSION

The States respectfully request that the Court grant this motion for preliminary injunction and enjoin implementation of the IFRs.

Dated: November 9, 2017

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JULIE WENG-GUTIERREZ
Senior Assistant Attorney General

/s/ R. Matthew Wise
/s/ Karli Eisenberg
/s/ Michele L. Wong

R. MATTHEW WISE
KARLI EISENBERG
MICHELE L. WONG
Deputy Attorneys General
Attorneys for Plaintiff the State of California

MATTHEW P. DENN
Attorney General of Delaware
AARON R. GOLDSTEIN
State Solicitor
LAKRESHA S ROBERTS
Chief Deputy Attorney General
JESSICA M. WILLEY
Deputy Attorney General
Attorneys for Plaintiff the State of Delaware

BRIAN E. FROSH
Attorney General of Maryland
CAROLYN A. QUATTROCKI
Deputy Attorney General
STEVE M. SULLIVAN
Solicitor General
KIMBERLY S. CAMMARATA
Director, Health Education and Advocacy
Attorneys for Plaintiff the State of Maryland

ERIC T. SCHNEIDERMAN
Attorney General of New York
LISA LANDAU
Bureau Chief, Health Care Bureau
SARA HAVIVA MARK
Special Counsel
ELIZABETH CHESLER
Assistant Attorney General
Attorneys for Plaintiff the State of New York

MARK R. HERRING
Attorney General of Virginia
SAMUEL T. TOWELL
Deputy Attorney General
Attorneys for Plaintiff the Commonwealth of Virginia

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XAVIER BECERRA, SBN 118517
Attorney General of California
JULIE WENG-GUTIERREZ, SBN 179277
Senior Assistant Attorney General
R. MATTHEW WISE, SBN 238485
KARLI EISENBERG, SBN 281923
MICHELE L. WONG, SBN 167176
Deputy Attorneys General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-6046
Fax: (916) 324-8853
E-mail: Matthew.Wise@doj.ca.gov
Attorneys for Plaintiff State of California, by and through Attorney General Xavier Becerra

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, STATE OF DELAWARE, STATE OF MARYLAND, STATE OF NEW YORK, STATE OF VIRGINIA, Plaintiffs, **v.** **DON J. WRIGHT, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF LABOR; U.S. DEPARTMENT OF LABOR; STEVEN MNUCHIN, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF THE TREASURY; U.S. DEPARTMENT OF THE TREASURY; DOES 1-100,** Defendants.	4:17-cv-05783-HSG **DECLARATION OF DANIEL GROSSMAN IN SUPPORT OF STATES' MOTION FOR PRELIMINARY INJUNCTION**

I, Daniel Grossman, MD, FACOG, declare:

1. I am a Professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco (UCSF) and an obstetrician-gynecologist with over 20 years of clinical experience. I currently provide clinical services, including abortion services, at Zuckerberg San Francisco General Hospital. I am also a Fellow of the American College of Obstetricians and Gynecologists (ACOG), where I previously served as Vice Chair of the Committee on Practice Bulletins for Gynecology. I am currently Vice Chair of the ACOG Committee on Health Care for Underserved Women. I am also a Fellow of the Society of Family Planning and a member of the American Public Health Association (APHA). Additionally, I serve as Director of Advancing New Standards in Reproductive Health (ANSIRH), which is part of the Bixby Center for Global Reproductive Health at UCSF. I am also a Senior Advisor at Ibis Reproductive Health, a nonprofit research organization. My research has been supported by grants from federal agencies and private foundations. I have published over 140 articles in peer-reviewed journals, and I am a member of the Editorial Board of the journal Contraception.

2. I earned a B.S. in Molecular Biophysics and Biochemistry from Yale University and an M.D. from Stanford University School of Medicine. I completed a residency in Obstetrics, Gynecology, and Reproductive Sciences at UCSF.

3. The UCSF Bixby Center advances reproductive health policy and practice worldwide through research, training and advocacy. Our work informs evidence-based reproductive and sexual health policies, treatment and care guidelines to save women's lives around the world. We work to ensure that women have the power to plan their families through access to safe and effective birth control, abortion services, sex education, and childbirth and HIV/AIDS care—regardless of their age, ethnicity, income, or where they live.

4. ANSIRH is a collaborative research group at the Bixby Center that conducts innovative, rigorous, multidisciplinary research on complex issues related to people's sexual and reproductive lives. Our work is informed by an understanding of the role that structural inequities, including gender, race/ethnicity, socioeconomic background, and geographic location, play in shaping health. We believe in the importance of research in advancing evidence-based policy,

practice, and public discourse to improve reproductive wellbeing. We are dedicated to ensuring that reproductive health care and policy are grounded in evidence.

5. Almost half of all pregnancies in the United States are unintended; the vast majority of unintended pregnancies are attributed to nonuse or inconsistent use of contraceptives. Oral contraceptives and prescription-based hormonal contraceptives, including the patch and ring, are 91% effective with typical use and 99% effective with perfect use. The prescription requirement may be a barrier for some women to obtaining and consistently using these methods. In 2011, I led a nationally representative survey of 2,046 adult U.S. women who were at risk of unintended pregnancy to explore their experiences accessing prescription-based hormonal contraception.[1] The survey was conducted in English and Spanish and included questions about participants' background, contraceptive use, and experiences obtaining and filling prescriptions for hormonal contraceptives.

6. Of the survey participants, 1,385 women (68 percent) had ever tried to obtain a prescription for hormonal birth control, and 400 of these women (29 percent) had experienced difficulties. The most common barrier was cost barriers or lack of insurance coverage (182 women; 14 percent). Higher proportions of women under age 35 (32%), women with less than a high school education (48%), Hispanic women (48%), Spanish speakers (68%), unmarried cohabiting women (40%), women whose incomes were less than or equal to 200% of the federal poverty level (37%), and uninsured women (55%) had difficulties obtaining or refilling prescriptions. This survey provides a baseline of access difficulties before the Affordable Care Act's contraceptive coverage guarantee went into effect.

7. Interpregnancy intervals of less than 18 months and high rates of unintended pregnancy are associated with adverse birth outcomes. Immediate postpartum placement of IUDs and implants has been shown to reduce rapid repeat pregnancy and yield high contraceptive use rates. A survey I was involved with sought to determine how women's contraceptive choices

[1] K. Grindlay and D. Grossman. 2016. "Prescription Birth Control Among U.S. Women at Risk of Unintended Pregnancy, *Journal of Women's Health* 25: 249-54. Available at https://www.ncbi.nlm.nih.gov/pubmed/26666711.

varied from their preferences in the postpartum period.[2] In 2011, the Texas legislature cut state funding for family planning. Four hundred women in El Paso and 403 in Austin were interviewed at three, six, and nine months postpartum to determine whether they preferred a more effective method of contraception than they were currently using.

8. The survey's results showed that, although only 13 percent of women were using long-acting reversible contraception (LARC), 25 percent showed an explicit preference for this method, and 34 percent showed a latent preference Additionally, although only 17 percent of women were using male or female sterilization to prevent pregnancy, 19 percent had an explicit preference and 44 percent had a latent preference for sterilization. At six months postpartum, only 25 percent of 246 women who wanted more children and desired LARC were actually using a LARC method. At the same time period, only 41 percent of 283 women who did not want more children and desired a permanent method of contraception had actually obtained a permanent method for themselves or their partner. The survey also showed that women from advantaged groups (income over $75,000) were far more likely to actually use a LARC method when they preferred LARC. The inability of low-income and uninsured women and couples to obtain or use LARC in this time period in Texas is consistent with reports from family planning leaders regarding the impact of the 2011 funding cuts.

9. The results of these two surveys from 2011 show the difficulties posed to women in accessing and using their desired contraceptive options prior to the Affordable Care Act's contraceptive equity provisions. Other research has clearly demonstrated that women's out-of-pocket expenditures have declined significantly and their access to contraceptives has increased dramatically since these provisions went into place. For instance, women now save an average of 20% annually in out-of-pocket expenses, including $248 savings for IUDs and $255 for the contraceptive pill.[3] There has been a 2.3 percentage-point increase in women choosing

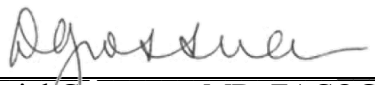
[2] J.E. Potter *et al.* 2017. "Contraception After Delivery Among Publicly Insured Women in Texas: Use Compared with Preference," *Obstetrics & Gynecology* 130: 393-402. Available at https://www.ncbi.nlm.nih.gov/pubmed/28697112.

[3] N.V. Becker, *et al.* 2015. "Women Saw Large Decrease In Out-Of-Pocket Spending For Contraceptives After ACA Mandate Removed Cost Sharing," *Health Affairs* 34. Available at http://content.healthaffairs.org/content/34/7/1204.abstract#aff-2.

prescription contraceptives, driven by increased selection of longer-term methods, as well as a 52 percentage-point increase in the number of women who have no out-of-pocket costs for the contraceptive pill.[4] Finally, there has been a 45 percentage-point drop in the number of women who would have out-of-pocket costs for a hormonal IUD.[5] If employers are permitted to exercise religious or moral objections and employer-sponsored health insurance ceases to cover the full range of FDA-approved birth control options, affected women will face cost barriers to accessing prescription contraception and some will no longer be able to access LARC methods if they desire them. This, in turn, will likely lead to an increase in unintended pregnancy, including closely spaced pregnancy, reversing the positive trends in recent years.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on October 27, 2017, in Oakland, California.



Daniel Grossman, MD, FACOG
Professor, Department of Obstetrics,
Gynecology & Reproductive Services
University of California, San Francisco

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XAVIER BECERRA, SBN 118517
Attorney General of California
JULIE WENG-GUTIERREZ, SBN 179277
Senior Assistant Attorney General
R. MATTHEW WISE, SBN 238485
KARLI EISENBERG, SBN 281923
MICHELE L. WONG, SBN 167176
Deputy Attorneys General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-6046
Fax: (916) 324-8853
E-mail: Matthew.Wise@doj.ca.gov
Attorneys for Plaintiff State of California, by and through Attorney General Xavier Becerra

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA,

Plaintiff,

v.

DON J. WRIGHT, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF LABOR; U.S. DEPARTMENT OF LABOR; STEVEN MNUCHIN, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF THE TREASURY; U.S. DEPARTMENT OF THE TREASURY; DOES 1-100,

Defendants.

4:17-cv-05783-KAW

DECLARATION OF HAL C. LAWRENCE, III, MD, FACOG, IN SUPPORT OF STATE OF CALIFORNIA'S MOTION FOR PRELIMINARY INJUNCTION

I, Hal C. Lawrence, III, MD, FACOG, declare:

1. I am the Executive Vice President and Chief Executive Officer of the American College of Obstetricians and Gynecologists (ACOG). I have served in my current position since July 1, 2011. Prior to my current position, I was the Vice President, Practice Activities for ACOG. As Executive Vice President and Chief Executive Officer, I oversee the day-to-day operations of ACOG, including the development and publication of ACOG Committee Opinions.

2. Founded in 1951, ACOG is the specialty's premier professional membership organization dedicated to the improvement of women's health. With more than 58,000 members, the College is a 501(c)(3) organization and its activities include producing practice guidelines and other educational material.

3. ACOG periodically releases Committee Opinions. Committee Opinions represent an ACOG committee's assessment of emerging issues in obstetric and gynecologic practice and are reviewed regularly for accuracy.

4. Per ACOG Committee Opinion 615, "Access to Contraception," released January 2015 and reaffirmed 2017, a true and correct copy of which is attached as Exhibit A, ACOG "supports access to comprehensive contraceptive care and contraceptive methods as an integral component of women's health care." ACOG recommends and supports "[f]ull implementation of the Affordable Care Act (ACA) requirement that new and revised private health insurance plans cover all U.S. Food and Drug Administration (FDA)-approved contraceptives without cost sharing, including nonequivalent options from within one method category" and "[e]asily accessibly alternative contraceptive coverage for women who receive health insurance through employers and plans exempted from the contraceptive coverage requirement."

5. Per ACOG Committee Opinion 615, "Access to Contraception," released January 2015 and reaffirmed 2017, a true and correct copy of which is attached as Exhibit A, ACOG states that "[t]he benefits of contraception … are widely recognized and include improved health and well-being, reduced global maternal mortality, health benefits of pregnancy spacing for maternal and child health, female engagement in the work force, and economic self-sufficiency for women" and that "[u]niversal coverage of contraceptives is cost effective and reduces

unintended pregnancy and abortion rates. Additionally, noncontraceptive benefits may include decreased bleeding and pain with menstrual periods and reduced risk of gynecologic disorders, including a decreased risk of endometrial and ovarian cancer."

6. Per ACOG Committee Opinion 615, "Access to Contraception," released January 2015 and reaffirmed 2017, a true and correct copy of which is attached as Exhibit A, ACOG supports "women's right to decide whether to have children, to determine the number and spacing of their children, and to have the information, education, and access to health services to make these choices" and declares that "[t]he cost of unintended pregnancy is high: women must either carry an unplanned pregnancy to term and keep the baby or make a decision for adoption, or choose to undergo abortion … Facilitating affordable access to contraceptives would not only improve health but also would reduce health care costs, as each dollar spent on publicly funded contraceptive services saves the U.S. health care system nearly $6. The most effective way to reduce abortion rates is to prevent unintended pregnancy by improving access to consistent, effective, and affordable contraception."

7. Per ACOG Committee Opinion 615, "Access to Contraception," released January 2015 and reaffirmed 2017, a true and correct copy of which is attached as Exhibit A, ACOG states that "[w]omen covered through exempted employers, as well as women such as unauthorized immigrants who remain uninsured in spite of the ACA, will not benefit from coverage introduced by the ACA. For these women, cost barriers will persist and the most effective methods, such as IUDs and the contraceptive implant, likely will remain out of reach."

8. Per ACOG Committee Opinion 654, "Reproductive Life Planning to Reduce Unintended Pregnancy," released February 2016, a true and correct copy of which is attached as Exhibit B, ACOG declares that "[u]nintended pregnancy can be associated with maternal depression, an increased risk of physical violence to the pregnant woman, late prenatal care, and undue financial burdens in many families. Short inter-pregnancy (preceding birth to subsequent pregnancy) intervals of less than 18 months because of unintended pregnancy can be associated with poor obstetric outcomes. Unintended pregnancies account for most of the 1.1 million

abortions that occur annually. Infants born as a result of unintended pregnancies are at greater risk of birth defects, low birth weight, and poor mental and physical functioning in early childhood."

9. Per ACOG Committee Opinion 654, "Reproductive Life Planning to Reduce Unintended Pregnancy," released February 2016, a true and correct copy of which is attached as Exhibit B, ACOG affirms that "[a]t the core of unintended pregnancy is the unmet need for contraception, inconsistent or incorrect use of contraceptive methods, and misperceptions about adverse effects, particularly for hormonal methods or long-acting reversible contraceptives. At least 52% of unintended pregnancies occur among women who are not using any contraception, and 43% occur because of inconsistent or incorrect use of contraceptive methods…[W]hen contraceptive methods are provided at no cost, women are more likely to choose the most effective methods, which results in lower rates of unintended pregnancy, abortion, and births among adolescents."

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on October 13, 2017, in Washington, DC.

Hal C. Lawrence, III, MD, FACOG
Executive Vice President and
Chief Executive Officer
The American College of Obstetricians
and Gynecologists

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The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 615 • January 2015
Reaffirmed 2017

Committee on Health Care for Underserved Women

This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Access to Contraception

ABSTRACT: Nearly all U.S. women who have ever had sexual intercourse have used some form of contraception at some point during their reproductive lives. However, multiple barriers prevent women from obtaining contraceptives or using them effectively and consistently. All women should have unhindered and affordable access to all U.S. Food and Drug Administration-approved contraceptives. This Committee Opinion reviews barriers to contraceptive access and offers strategies to improve access.

Recommendations

The American College of Obstetricians and Gynecologists (the College) supports access to comprehensive contraceptive care and contraceptive methods as an integral component of women's health care and is committed to encouraging and upholding policies and actions that ensure the availability of affordable and accessible contraceptive care and contraceptive methods. In order to accomplish this goal, the College recommends and supports the following:

- Full implementation of the Affordable Care Act (ACA) requirement that new and revised private health insurance plans cover all U.S. Food and Drug Administration (FDA)-approved contraceptives without cost sharing, including nonequivalent options from within one method category (eg, levonorgestrel as well as copper intrauterine devices [IUDs])
- Easily accessible alternative contraceptive coverage for women who receive health insurance through employers and plans exempted from the contraceptive coverage requirement
- Medicaid expansion in all states, an action critical to the ability of low-income women to obtain improved access to contraceptives
- Adequate funding for the federal Title X family planning program and Medicaid family planning services to ensure contraceptive availability for low-income women, including the use of public funds for contraceptive provision at the time of abortion
- Sufficient compensation for contraceptive services by public and private payers to ensure access, including appropriate payment for clinician services and acquisition-cost reimbursement for supplies
- Age-appropriate, medically accurate, comprehensive sexuality education that includes information on abstinence as well as the full range of FDA-approved contraceptives
- Confidential, comprehensive contraceptive care and access to contraceptive methods for adolescents without mandated parental notification or consent, including confidentiality in billing and insurance claims processing procedures
- The right of women to receive prescribed contraceptives or an immediate informed referral from all pharmacies
- Prompt referral to an appropriate health care provider by clinicians, religiously affiliated hospitals, and others who do not provide contraceptive services
- Evaluation of effects on contraceptive access in a community before hospital mergers and affiliations are considered or approved
- Efforts to increase access to emergency contraception, including removal of the age restriction for all levonorgestrel emergency contraception products, to create true over-the-counter access
- Over-the-counter access to oral contraceptives with accompanying full insurance coverage or cost supports

- Payment and practice policies that support provision of 3–13 month supplies of combined hormonal methods to improve contraceptive continuation
- Provision of medically accurate public and health care provider education regarding contraception
- Improved access to postpartum sterilization, including revision of federal consent requirements for women covered by Medicaid, the Indian Health Service, the U.S. military, or other government health insurance
- Institutional and payment policies that support immediate postpartum and postabortion provision of contraception, including reimbursement for long-acting reversible contraception (LARC) devices separate from the global fee for delivery, and coverage for contraceptive care and contraceptive methods provided on the same day as an abortion procedure
- Inclusion of all contraceptive methods, including LARC, on all payer and hospital formularies
- Funding for research to identify effective strategies to reduce health inequities in unintended pregnancy and access to contraception

Background

The benefits of contraception, named as one of the 10 great public health achievements of the 20th century by the Centers for Disease Control and Prevention, are widely recognized and include improved health and well-being, reduced global maternal mortality, health benefits of pregnancy spacing for maternal and child health, female engagement in the work force, and economic self-sufficiency for women (1). Ninety-nine percent of U.S. women who have been sexually active report having used some form of contraception, and 87.5% report use of a highly effective reversible method (2). Universal coverage of contraceptives is cost effective and reduces unintended pregnancy and abortion rates (3). Additionally, noncontraceptive benefits may include decreased bleeding and pain with menstrual periods and reduced risk of gynecologic disorders, including a decreased risk of endometrial and ovarian cancer.

Unintended Pregnancy in the United States and the Case for Contraceptive Access

The College supports women's right to decide whether to have children, to determine the number and spacing of their children, and to have the information, education, and access to health services to make those choices (4). Women must have access to reproductive health care, including the full range of contraceptive choices, to fulfill these rights.

Unintended pregnancy and abortion rates are higher in the United States than in most other developed countries, and low-income women have disproportionately high rates (5). Currently, 49% of pregnancies are unintended (5). Reducing this high rate is a national priority reflected in the Healthy People 2020 goal to decrease the rate of unintended pregnancies from 49% to 44% (6). The human cost of unintended pregnancy is high: women must either carry an unplanned pregnancy to term and keep the baby or make a decision for adoption, or choose to undergo abortion. Women and their families may struggle with this challenge for medical, ethical, social, legal, and financial reasons. Additionally, U.S. births from unintended pregnancies resulted in approximately $12.5 billion in government expenditures in 2008 (7). Facilitating affordable access to contraceptives would not only improve health but also would reduce health care costs, as each dollar spent on publicly funded contraceptive services saves the U.S. health care system nearly $6 (8). The most effective way to reduce abortion rates is to prevent unintended pregnancy by improving access to consistent, effective, and affordable contraception.

Knowledge Deficits

Lack of knowledge, misperceptions, and exaggerated concerns about the safety of contraceptive methods are major barriers to contraceptive use. There has been a focus on abstinence-only sexuality education for young people in the United States despite research demonstrating its ineffectiveness in increasing age of sexual debut and decreasing number of partners and other risky behavior (9, 10). In contrast, data suggest the effectiveness of comprehensive sexuality education in achieving these outcomes (10). The emphasis on abstinence-only education may have in part led to widespread misperceptions of contraceptive effectiveness, mechanisms of action, and safety that can have an effect on contraceptive use and method selection (11). For example, many individuals have unfounded concerns that oral contraceptives are linked to major health problems or that IUDs carry a high risk of infection (12, 13). Many individuals also incorrectly believe certain types of contraception to be abortifacients (14). None of the FDA-approved contraceptive methods are abortifacients because they do not interfere with a pregnancy and are not effective after a fertilized egg has implanted successfully in the uterus (15).

Health care providers also may have knowledge deficits that can hamper their ability to offer appropriate contraceptive methods to their patients. For example, many clinicians are uncertain about the risks and benefits of IUDs and lack knowledge about correct patient selection and contraindications (16–18). Improving health care provider and patient knowledge about contraceptive methods would improve access and allow for safer use.

Restrictive Legal and Legislative Climate

Unfavorable legal rulings and restrictive legislative measures can impede access to contraceptives for minors and adults and interfere with the patient–physician relationship by impeding contraceptive counseling, coverage, and provision. With the U.S. Supreme Court's *Burwell v Hobby Lobby* ruling that a closely held corporation can exclude contraceptive coverage from workers' insurance

benefits based on the company owner's religious beliefs, additional employers may now refuse to comply with federal birth control coverage requirements. Some corporations also may use the legal process to challenge laws in states that ensure equitable contraceptive coverage.

Additionally, state lawmakers may be emboldened to further restrict access to contraception. For example, in 2012, Arizona revisited its decade-old law that ensures equitable insurance coverage for birth control and authorized a much broader class of employers to exclude this coverage from employee health insurance plans. In 2013, bills designed to weaken existing contraceptive equity laws or to allow employers—secular and religious—to deny contraceptive coverage to their workers were introduced in more than a dozen states.

Measures that define life as beginning at fertilization and, thereby, conferring the legal status of "personhood" on fertilized eggs also pose a significant risk to contraceptive access. Supporters of "personhood" measures argue erroneously that most methods of contraception act as abortifacients because they may prevent a fertilized egg from implanting; if these "personhood" measures were to be implemented, contraception opponents may assert that hormonal contraceptive methods and IUDs are illegal.

Currently, 20 states restrict some minors' ability to consent to contraceptive services (19). Although the Title X family planning program and Medicaid require that minors receive confidential health services, state and federal legislation requiring parental notification, parental consent, or both for minors who receive contraceptive care has been increasingly proposed (20). Even though policies should encourage and facilitate communication between a minor and her parent or guardian when appropriate, legal barriers and deference to parental involvement should not stand in the way of needed contraceptive care for adolescents who request confidential services.

Cost and Insurance Coverage

More than one half of the 37 million U.S. women who needed contraceptive services in 2010 were in need of publicly funded services, either because they had an income below 250% of the federal poverty level or because they were younger than 20 years (8). One in four women in the United States who obtain contraceptive services seek these services at publicly funded family planning clinics (21). The number of women in need of publicly funded contraceptive services increased by 17%, or nearly three million women, from 2000 to 2010 (8). Expanding access to publicly funded family planning services produces cost savings by reducing unintended pregnancy. In 2010, federal and state governments saved an estimated $7.6 billion because of contraceptive services provided at publicly funded centers (8). As the ACA goes into effect, obstetrician–gynecologists can be strong advocates for continued expansion of affordable contraceptive access, which has been shown to be cost neutral at worst and cost saving at best (22, 23).

High out-of-pocket costs, deductibles, and copayments for contraception also limit contraceptive access even for those with private health insurance. Most private health plans cover prescription contraception, but cost sharing and formularies vary (24). In 2000, the federal Equal Employment Opportunity Commission concluded that a company's failure to cover contraception is sex discrimination under Title VII of the Civil Rights Act as amended by the 1978 Pregnancy Discrimination Act (25). However, even when contraception is covered, women pay approximately 60% of the cost out of pocket compared with the typical out-of-pocket cost of only 33% for noncontraceptive drugs (26).

Under the ACA, all FDA-approved contraceptive methods, sterilization procedures, and patient contraceptive education and counseling are covered for women without cost sharing by all new and revised health plans and issuers as of the first full plan year beginning on or after August 1, 2012. This requirement also applies to those enrolled in Medicaid expansion programs. However, many employers are now exempt from these requirements because of regulatory and court decisions. Women covered through exempted employers, as well as women such as unauthorized immigrants who remain uninsured in spite of the ACA, will not benefit from coverage introduced by the ACA. For these women, cost barriers will persist and the most effective methods, such as IUDs and the contraceptive implant, likely will remain out of reach.

Other insurance barriers include limits on the number of contraceptive products dispensed. Data show that provision of a year's supply of contraceptives is cost effective and improves adherence and continuation rates (27). Insurance plan restrictions prevent 73% of women from receiving more than a single month's supply of contraception at a time, yet most women are unable to obtain contraceptive refills on a timely basis (26, 28, 29).

Some insurers, clinic systems, or pharmacy and therapeutics committees also require women to "fail" certain contraceptive methods before a more expensive method, such as an IUD or implant, will be covered. All FDA-approved contraceptive methods should be available to all insured women without cost sharing and without the need to "fail" certain methods first. In the absence of contraindications, patient choice and efficacy should be the principal factors in choosing one method of contraception over another.

Another strategy for improving access to contraception is to allow over-the-counter access to oral contraceptive pills (30). However, over-the-counter provision may improve access only if over-the-counter products also are covered by insurance or other cost supports in order to make them financially accessible to low-income women.

Objection to Contraception

Efforts to frame access as an issue of conscience or reli-

gious belief rather than as essential health care have grave consequences for women and can create major obstacles to obtaining insurance coverage, receiving prescriptions from health care providers, obtaining medications from pharmacists, and receiving care at hospitals. Ten of the 25 largest health systems in the country are Catholic-sponsored facilities (31). Mergers between religious (predominantly Catholic) health care facilities and other hospitals are common and often result in decreased access to reproductive health services, including contraception (31). Advocacy by clinicians and community leaders has been effective in preserving access in some communities (32, 33).

Pharmacist refusals to fill contraceptive prescriptions or provide emergency contraception, as well as pharmacies that refuse to stock contraceptives, are considerable barriers. Although some women have access to an alternative pharmacy, women in areas where pharmacies and pharmacists are limited, such as rural areas, may find insurmountable obstacles to obtaining prescribed contraception. In eight states, laws specifically prohibit pharmacy or pharmacist refusal; seven states allow refusal but prohibit pharmacist obstruction of patients' receipt of medications; and six states specifically allow pharmacists to refuse to dispense legally prescribed medications without protections for patients, such as a referral requirement (34). The American Pharmacists Association supports the establishment of systems to ensure patient access to contraception when individual pharmacists refuse provision (35). The College supports unhindered access to contraception for all women and opposes health care provider and institutional refusals that create obstacles to contraceptive access.

Unnecessary Medical Practices

Common medical practices prevent easy initiation of contraception. 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 (36).

Another common practice is requiring one medical appointment to discuss initiation of a LARC method and a second for placement of the device or requiring two visits to perform and obtain results from sexually transmitted infection testing. Clinicians are encouraged to initiate and place LARC in a single visit as long as pregnancy may be reasonably excluded. Sexually transmitted infection testing can occur on the same day as LARC placement, and women do not require cervical preparation for insertion (37, 38). Insurer payment policies should support same-day provision by providing appropriate payment and reimbursement for multiple services performed during a single visit. Similarly, health care providers should encourage patients initiating combined hormonal contraceptives to start on the day of the medical visit (38).

Institutional and Payment Barriers

Appropriate compensation for contraceptive services enables health care providers to provide the full range of contraceptive options, which improves quality of care and optimizes health outcomes. Public and private payers can contribute to efforts to improve contraceptive access by working with health care providers to ensure appropriate payment for clinician services and to provide reimbursement for contraceptive devices at acquisition cost levels.

Twenty-seven percent of reproductive-aged women choose to undergo permanent sterilization once they have completed childbearing (39). Institutional and payment barriers often prevent women from receiving this desired procedure. Many sterilization procedures are planned immediately postpartum, which is an advantageous time because the woman is not pregnant, is within a medical facility, and often has insurance coverage. However, many women do not obtain their planned postpartum sterilization because of limited operating room availability, lack of motivation or coordination on the part of the health care team (obstetricians, nurses, and anesthesiologists), perceived increased risk because of the postpartum state, or misplaced or incomplete sterilization consent forms. In one study, almost 50% of women who did not receive a requested postpartum sterilization were pregnant again within 1 year (40). Federal regulations require a specific sterilization consent form to be signed 30 days before sterilization for women enrolled in Medicaid or covered by other government insurance (41). This requirement eliminates immediate postpartum sterilization as an option if the paperwork is not completed in advance and available at the time of delivery. This regulation, created to protect women from coerced sterilization, also can pose a barrier to a desired sterilization. Women with commercial or private insurance who desire sterilization are not mandated to follow the same consent rules. Revision of the federal consent mandate in order to create fair and equitable access to sterilization services for women enrolled in Medicaid or covered by other government insurance would improve access. These revisions can be balanced by educating patients and obtaining informed consent to address concerns of coercion (41).

Highly effective LARC methods are underutilized, and promoting affordable access to LARC methods for current low-use populations, including adolescents and nulliparous women, may help reduce unintended pregnancy (37). In addition to the high up-front costs associated with these methods, another common barrier is inadequate reimbursement for LARC devices in certain settings. Providing effective contraception postpartum and postabortion can be ideal because the patient is often highly motivated to avoid pregnancy, is within the health care system, and is not pregnant. Appropriate reimburse-

ment for LARC methods immediately postpartum or postabortion can be difficult to obtain.

Health Care Inequities

Rates of adverse reproductive health outcomes are higher among low-income and minority women. Unintended pregnancy rates are highest among those least able to afford contraception and have increased substantially over the past decade (5). The unintended pregnancy rate for poor women is more than five times the rate for women in the highest income bracket (5). Low-income minority women have higher rates of nonuse of contraceptives and are more likely to use less effective reversible methods such as condoms (42). Additionally, low-income women face health system barriers to contraceptive access because they are more likely to be uninsured, a major risk factor for nonuse of prescription contraceptives (42). Publicly funded programs that support family planning services, including Title X and Medicaid, are increasingly underfunded and cannot bridge the gap in access for vulnerable women. To address these barriers, the ACA has encouraged states to expand Medicaid eligibility for family planning services to greater numbers of low-income women. Also, in states that choose to expand Medicaid under the ACA, fewer poor women will lose Medicaid eligibility postpartum.

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The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 654 • February 2016

Committee on Health Care for Underserved Women

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women. Member contributors included Wanda Nicholson, MD, MPH. This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Reproductive Life Planning to Reduce Unintended Pregnancy

ABSTRACT: Approximately one half (51%) of the 6 million pregnancies each year in the United States are unintended. A reproductive life plan is a set of personal goals regarding whether, when, and how to have children based on individual priorities, resources, and values. A lack of reproductive life planning, limited access to contraception, and inconsistent use of contraceptive methods contribute to unintended pregnancy. The American College of Obstetricians and Gynecologists strongly supports women's access to comprehensive and culturally appropriate reproductive life planning and encourages obstetrician–gynecologists and other health care providers to use every patient encounter as an opportunity to talk with patients about their pregnancy intentions and to support initiatives that promote access to and availability of all effective contraceptive methods.

Recommendations

The U.S. Department of Health and Human Services' Healthy People 2020 objectives call for a 10% reduction in unintended pregnancy over the next 10 years (1). Obstetrician–gynecologists can help to achieve this goal if they

- take advantage of each patient visit as an important teachable moment to assess each woman's short- and long-term reproductive plans.
- engage each patient in supportive, respectful conversation about her pregnancy intentions and provide preconception or contraceptive counseling based on the woman's desires and preferences.
- discuss the range of contraceptive methods and the perceived barriers to contraception, and engage in shared decision making to optimize contraceptive choices with women who desire to avoid pregnancy.
- educate women about the importance of pregnancy planning and child spacing to reduce adverse pregnancy outcomes.
- maintain awareness of the Affordable Care Act's contraception coverage provisions as well as local community initiatives that improve women's knowledge of how to access low- or no-cost contraception.
- support initiatives that reduce poverty and racial and ethnic health inequities, both of which are major drivers of unintended pregnancy.

Background

Public Health Burden of Unintended Pregnancy

An *unintended pregnancy* is defined as a pregnancy that is mistimed or unwanted (2). The 3.4 million unintended pregnancies each year in the United States account for approximately one half of all pregnancies (3) and can result in negative health consequences for women and children and an enormous financial burden to the health care system (4, 5). Unintended pregnancy can be associated with maternal depression, an increased risk of physical violence to the pregnant woman, late prenatal care, and undue financial burdens in many families (6). Short interpregnancy (preceding birth to subsequent pregnancy) intervals of less than 18 months because of unintended pregnancy can be associated with poor obstetric outcomes (7, 8). Unintended pregnancies account for most of the 1.1 million abortions that occur annually (3, 9, 10). Infants born as a result of unintended pregnancies are at greater risk of birth defects, low birth weight, and poor mental and physical functioning in early childhood (8).

Initiatives to Promote Effective Reproductive Life Planning

A reproductive life plan is a set of personal goals regarding whether, when, and how to have children based on individual priorities, resources, and values (11). Practitioners often limit discussions about reproductive life planning to appointments for contraception or to the well-woman visit. But there are a number of opportunities to integrate reproductive life planning into other clinical encounters, including acute care and prenatal visits. Dr. Jeanne Conry launched the initiative "Every Woman, Every Time" in 2013 during her American College of Obstetricians and Gynecologists' presidential address (12). The campaign encourages clinicians to address reproductive health choices every time a woman has contact with the health care system. Obstetrician–gynecologists and other health care providers should use every encounter not only to discuss women's preferences for contraception, but also to counsel women about healthy lifestyle changes they can make to improve their health status before pregnancy to help ensure healthy future pregnancies. Every patient encounter, regardless of the chief reason for the visit, is an important "teachable moment" (13) to reduce unintended pregnancy, promote maternal health, and improve pregnancy outcomes. The first step in helping women plan their pregnancies is asking the right questions.

The One Key Question® Initiative promotes direct screening for women's pregnancy intentions as a core component of high quality, primary preventive care services (14). The initiative proposes (see Box 1) that clinicians begin every conversation with women, aged 18–50 years, with the following question, "Would you like to become pregnant in the next year?" If the answer is "no," clinicians can discuss pregnancy prevention, including education and counseling on all available contraceptive options, and help each woman arrive at an appropriate choice based on her health status, personal values, and preferences. Counseling should include guidance on the correct use of the chosen contraceptive method and the need for consistent use. If the response is "yes," clinicians can provide preconception counseling and discuss evidence-based lifestyle modifications to optimize health status in preparation for future pregnancies.

The *Providing Quality Family Planning Services* report (15), published by the U.S. Centers for Disease Control and Prevention and the Department of Health and Human Services, provides evidence-based recommendations on how to prevent or achieve pregnancy based on the preferences and desires of women, their partners, and couples. The report supports the need for effective and efficient patient–practitioner communication about reproductive life planning using a series of three questions (see Box 1) and emphasizes the specific need for respectful engagement of women across demographic spectrums. Some women, particularly minority women, lower income women, and adolescents, can be mistrustful of health care practitioners and, therefore, reluctant to discuss their sexual activities or fully express their contraceptive needs and reproductive goals. This brief series of questions can help patients and obstetrician–gynecologists or other health care providers to have open, honest discussions about pregnancy intentions, whether care is being provided in a family planning clinic, a private or public health care setting, or during an acute care visit.

The *Providing Quality Family Planning Services* report encourages clinicians to offer a full range of reproductive life planning services, such as pregnancy testing and counseling, helping women to achieve pregnancies, basic infertility services, preconception health, and services to prevent and treat sexually transmitted infections. Providing preventive health services for women during family planning visits is strongly recommended and designated as a high-value component of quality family planning services.

Box 1. Questions to Assess Women's Pregnancy Intentions

One Key Question®

- Would you like to become pregnant in the next year?

The Centers for Disease Control and Prevention's Quality Family Planning Recommendations

- Do you have any children now?
- Do you want to have (more) children?
- How many (more) children would you like to have and when?

Disparities in Unintended Pregnancy

Minority and low-income women are two to three times more likely to experience an unintended pregnancy compared to white or higher income women (2). Limited availability of the broad range of contraceptive methods in underserved areas or communities of color accounts for much of the disparity (16). Financial barriers can further reduce access and consistent use of women's contraceptive method of choice and contributes to income disparities in unintended pregnancy and abortion rates. The Institute of Medicine recommends patient education and counseling on all U.S. Food and Drug Administration-approved contraceptive methods as part of the core elements of preventive care services (17). Although the Affordable Care Act (18) includes the provision of comprehensive contraceptive services for most insured reproductive-aged women without deductibles or co-pays, there remain significant populations of women without coverage who cannot access these services (19–21).

Promoting Knowledge About Access and Consistent Use of Contraception

At the core of unintended pregnancy is the unmet need for contraception, inconsistent or incorrect use of contraceptive methods, and misperceptions about adverse effects, particularly for hormonal methods or long-acting reversible contraceptives. At least 52% of unintended pregnancies occur among women who are not using any contraception, and 43% occur because of inconsistent or incorrect use of contraceptive methods. The Contraceptive Choice Project (22), a prospective study of nearly 10,000 reproductive-aged women, evaluated the effect of structured contraception counseling and financial coverage on women's use of long-acting reversible contraceptives. The study found that structured counseling could be delivered effectively in a busy clinical setting and could improve a woman's knowledge and consistent use of her contraceptive method of choice. Findings from the study also indicate that when contraceptive methods are provided at no cost, women are more likely to choose the most effective methods, which results in lower rates of unintended pregnancy, abortion, and births among adolescents (23). Additional organized efforts to provide access and coverage for contraception, such as statewide initiatives in Iowa (24) and Colorado (25), have demonstrated similar results with regard to low- or no-cost access and women's consistent use of their method of choice. The American College of Obstetricians and Gynecologists strongly supports state and national efforts to improve and sustain access to contraception and encourages Fellows to support initiatives in their local communities that help provide low- or no-cost access to effective contraceptive methods.

Conclusions

Every woman who is capable of having a child should have a reproductive life plan. In order to reduce the rate of unintended pregnancy, obstetrician–gynecologists must focus on having respectful, meaningful conversations with patients about pregnancy intentions and must be willing to support efforts that promote access and consistent use of all contraceptive methods.

For More Information

These resources are for information only and are not meant to be comprehensive. Referral to these resources does not imply the American College of Obstetricians and Gynecologists' endorsement of the organization, the organization's web site, or the content of the resources. The resources may change without notice.

ACOG has identified additional resources on topics related to this document that may be helpful for ob-gyns, other health care providers, and patients. You may view these resources at www.acog.org/More-Info/UnintendedPregnancy.

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA; STATE OF NEW YORK; STATE OF DELAWARE; COMMONWEALTH OF VIRGINIA, Plaintiffs, **v.** **DON J. WRIGHT, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF LABOR; U.S. DEPARTMENT OF LABOR; STEVEN MNUCHIN, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF THE TREASURY; U.S. DEPARTMENT OF THE TREASURY; DOES 1-100,** Defendants.	4:17-cv-005783-KAW **DECLARATION OF KARYL RATTAY IN SUPPORT OF STATE OF CALIFORNIA'S MOTION FOR PRELIMINARY INJUNCTION**

DECLARATION OF KARYL T. RATTAY, M.D., M.S.

I, Karyl T. Rattay, M.D., M.S., Director of the Delaware Department of Health and Social Services, Division of Public Health, declare and say as follows:

1. I am the Director of the Delaware Division of Public Health (DPH) within the Department of Health and Social Services. I have served as Delaware's State Health Officer since May 2, 2009 and in similar positions for more than 15 years.

2. Under Title X of the Public Health Services Act, DPH offers a wide range of reproductive health services and supplies to both women and men comprised of physical examinations and reproductive health services including pap smears and clinical breast examinations; family planning counseling and education; birth control education, including screening and supplies; emergency contraception; pre-conceptional counseling; sterilization counseling, education and referral; testing for and treatment of sexually transmitted diseases; HIV education, counseling and testing; pregnancy testing;

3. DPH bases its fees for services and supplies on income, but no one is denied services if he or she is unable to pay. DPH's Title X program accepts Medicaid and other insurance and uses a sliding scale for cash payments. Regardless of the ability to pay, federal regulations require that all be served based on need rather than income. Women in need of contraception and other services who lose coverage as a result of the IFR's and seek assistance at DPH will increase the responsibilities of the already overwhelmed Title X program.

4. The Guttmacher Institute reports that, in 2011, 45% of all pregnancies in the United States were unintended, including three out of four pregnancies to women younger than 20. https://www.guttmacher.org/fact-sheet/state-facts-about-unintended-pregnancy-delaware. In 2010, the 57% rate of unintended pregnancies in Delaware was the highest in the nation at 62 per 1,000 women aged 15 to 44.

5. The financial impact of unintended pregnancy on Delaware resources is profound. According to the Guttmacher Institute,

> • In 2010, 3,300 or 71.3% of unplanned births in Delaware were publicly funded, compared with 68% nationally.
>
> • In Delaware in 2010, the federal and state governments spent $94.2 million on unintended pregnancies; of this, $58.2 million was paid by the federal government and $36.0 million was paid by the state.
>
> • The total public costs for unintended pregnancies in 2010 was $526 per woman aged 15–44 in Delaware, compared with $201 per woman nationally.

> • In 2010, public expenditures for family planning client services in Delaware totaled $7.2 million; this includes $5.6 million through Medicaid and $908,000 through Title X. Most states also use some of their own money (in addition to funds required to match federal grants) for family planning services. In 2010, Delaware contributed $693,000.

6. If the Interim Final Rules are enforced in Delaware, the impact on the health of Delaware would be profound. The Public Health Accreditation Board concluded that, "unintended births was higher in younger mothers, those with 12 years of schooling, with low income, among non-Hispanic Blacks or African Americans, higher in Kent and Sussex counties, and among those with Medicaid as insurer." It is universally accepted that poverty and maternal age are critical measures of maternal and child health. Reduction of insurance coverage via the IFR's will contribute to an increase in Delaware's nationally high unintended pregnancy rate as women forego needed contraception and other services. Increases in unintended pregnancies among at-risk populations without proper pre-natal care, due to lost insurance coverage, will increase the number of newborns in Delaware dealing with illness, physical challenges and cognitive impairment due to low birthweight and prematurity. The impact goes beyond contraception as these mothers and infants may face lifelong challenges with significant financial and societal costs.

7. The cost to Delaware Medicaid for the costs of birth alone for unintended pregnancies is almost $30,000,000.00 annually. I predict that, if the Interim Final Rules are enforced in Delaware, more women who lose access to contraceptives through their employer-sponsored plans will seek access to those services and products through DPH's programs, which will result in increased costs to the State, increasing the burden on the Delaware Medicaid program. I expect that the Medicaid enrollment will expand as preventable, unintended pregnancies and resulting healthcare needs drive women and families into poverty. Not only will the costs of births from unintended pregnancies increase, so will the lifetime medical costs of both mother and child.

8. As unintended pregnancies increase poverty levels for mothers and children, there will be

an impact on other types of social spending by Delaware. I expect that more families will qualify for TANF, SNAP, WIC and other social spending programs. The increase in enrollment in these programs will tax Delaware's already overburdened public assistance programs. In the lean economic times that Delaware is facing, programs such as Child Development Watch are already functioning well beyond capacity as increased pediatrician screenings are identifying higher numbers of substance exposed infants as well as babies and young children (0-3) with possible developmental delays. These services are vital to the health and development of Delaware's most vulnerable children, but further demands will lead to gaps and loss of services. Children will fall through the cracks due to lack of staff capacity and available state resources to serve these families.

9. I expect that educational costs for both mothers and children born of unintended pregnancies will rise. I predict that costs for early intervention services and IDEA-mandated services will steeply increase as more such children need such remedial services.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Karyl T. Rattay, M.D., M.S.

SWORN and SUBSCRIBED before me this __20th___day of October, 2017

XAVIER BECERRA, SBN 118517
Attorney General of California
JULIE WENG-GUTIERREZ, SBN 179277
Senior Assistant Attorney General
R. MATTHEW WISE, SBN 238485
KARLI EISENBERG, SBN 281923
MICHELE L. WONG, SBN 167176
Deputy Attorneys General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-6046
Fax: (916) 324-8853
E-mail: Matthew.Wise@doj.ca.gov
Attorneys for Plaintiff State of California, by and through Attorney General Xavier Becerra

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA,

Plaintiff,

v.

DON J. WRIGHT, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF LABOR; U.S. DEPARTMENT OF LABOR; STEVEN MNUCHIN, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF THE TREASURY; U.S. DEPARTMENT OF THE TREASURY; DOES 1-100,

Defendants.

4:17-cv-005783-HSG

DECLARATION OF MARI CANTWELL IN SUPPORT OF STATE OF CALIFORNIA'S MOTION FOR PRELIMINARY INJUNCTION

I, Mari Cantwell declare:

1. I am the Medicaid Director for the State of California and Chief Deputy Director of Health Care Programs at the California Department of Health Care Services (DHCS). I have held the Chief Deputy position since 2013 and the State Medicaid Director position since 2015. I have worked in the field of health care policy and finance for almost 20 years. Prior to the position I hold now, I served as the Deputy Director of Health Care Financing for DHCS, and previously as the Vice President of Finance Policy for the California Association of Public Hospitals and Health Systems. I hold a B.A. in Public Policy from Brown University, and a Masters in Public Policy with a focus in Health Policy from the University of California, Los Angeles.

2. As the State Medicaid Director and Chief Deputy Director of Health Care Programs at DHCS, my responsibilities include the management of California's Medicaid program under title XIX of the federal Social Security Act, referred to in California as "Medi-Cal." In this role, I oversee the Office of Family Planning (OFP) which is responsible for developing family planning policy in Medi-Cal and administering family planning-related programs in the purview of DHCS.

3. The OFP is charged by the California Legislature "to make available to citizens of the State who are of childbearing age comprehensive medical knowledge, assistance, and services relating to the planning of families." Cal. Welf. & Inst. Code § 14501(a). The purpose of family planning is to provide women and men a means by which they decide for themselves the number, timing, and spacing of their children. Family planning services are a covered Medi-Cal benefit for individuals eligible for full scope coverage under the Medi-Cal State Plan.

4. In addition to the availability of family planning services for traditional Medi-Cal eligible individuals, the OFP also administers the Family Planning, Access, Care, and Treatment (Family PACT) program. Family PACT is California's innovative approach to provide comprehensive family planning services to eligible low income men and women that do not otherwise qualify for full scope Medi-Cal coverage. In 2014-15, the most recent fiscal year for which data is available, Family PACT served approximately 1.38 million income eligible men and women of childbearing age at no cost through a network of approximately 2200 public and

private providers. Services include comprehensive education, assistance, and services relating to family planning.

5. Family PACT works to achieve the following key objectives: (1) to increase access to publicly-funded family planning services for low-income California residents who have no other source of health care coverage for family planning, (2) to increase the use of effective contraceptive methods by clients, (3) to promote improved reproductive health, and (4) to reduce the rate, overall number, and cost of unintended pregnancies.

6. When established by the California Legislature in 1996, Family PACT was funded solely through the California State General Fund. From December 1999 through June 2010, California received additional funding from the Centers for Medicare and Medicaid Services (CMS) through a Section 1115 Demonstration Waiver. In March 2011, California received federal approval to transition Family PACT to the Medi-Cal State Plan as an optional eligibility category pursuant to 42 U.S.C. 1396a(a)(10)(A)(ii)(XXI) , retroactive to July 2010.

7. Family PACT serves clients that are (1) California residents (2) with an income at or below 200% of the federal poverty guidelines (3) who have no other source of health care coverage for family planning services and (4) have a medical necessity for family planning services. Clients can receive services the day that they enroll. Enrollment must be renewed annually.

8. Family PACT enrollees receive services through various clinician providers, including private physicians in individual or group settings, nonprofit community-based clinics, OB/GYNs and physicians representing general practice, family practice, internal medicine, and pediatrics. Planned Parenthood provides approximately 35% of the family planning visits that are reimbursed by Family PACT. Medi-Cal licensed pharmacies and laboratories also participate by referrals from enrolled Family PACT clinicians.

9. Family PACT benefits include all FDA approved contraceptive methods and supplies, family planning counseling and education, sexually transmitted infection (STIs) testing and treatment, HIV screening, cervical cancer screening, male and female permanent contraception, and limited infertility services.

10. California and the federal government jointly fund the costs of the Family PACT program according to applicable Federal Medical Assistance Percentage (FMAP) rates provided in Medicaid. Family planning services and testing for STIs under Family PACT are reimbursed at a ninety percent FMAP rate . The diagnosis and treatment of STIs and other family planning-related services under Family PACT are reimbursed at a fifty percent FMAP rate. California provides the remainder of the funding needed to provide services to Family PACT enrollees.

11. Beginning in January 2014, when the Patient Protection and Affordable Care Act (ACA) was first implemented, many Family PACT clients became eligible for full scope Medi-Cal for the first time. A smaller proportion became eligible for subsidized private insurance through Covered California, if they met corresponding eligibility parameters including the required income threshold. Family PACT clients who transitioned to full scope Medi-Cal and coverage through Covered California were able to receive family planning services with their new coverage.

12. In addition, ACA regulations increased access to family planning services by generally requiring employers to provide insurance coverage for contraception at no cost to the employee. This coverage is subject to exemptions for churches and accommodations for nonprofits and closely-held for-profit corporations that claim a religious objection. Under the accommodation, the responsibility for contraceptive coverage is passed from the employer to the insurer, ensuring seamless coverage for the employee.

13. The ACA's implementation correlates with a decrease in Family PACT enrollees. The number of clients Family PACT served in 2014-15—1.38 million—decreased 17.9% from the previous fiscal year.

14. In particular, the number of Family PACT clients between 139% and 200% of the federal poverty guidelines decreased from 126,170 in 2013-14 to 67,867 in 2014-15.

15. It is my understanding that under the two interim final rules issued by the U.S. Health and Human Services Department, in conjunction with the U.S. Department of Labor and U.S. Department of Treasury, on October 6, 2017 (IFRs), certain employers could claim a religious or moral objection to providing contraceptive coverage and leave their employees without access to

"no cost" contraceptive coverage. This expanded exemption would effectively make contraceptive coverage optional for certain employers and their employees.

16. After considering this change in the law prescribed by the IFRs, I believe that some California women and covered dependents who could lose coverage could become eligible for the Family PACT program, provided they meet other requirements such as having income at or below 200% of the federal poverty level.

17. If, as a result of the IFRs, additional individuals become eligible for and enroll in Family PACT, this will result in increased financial obligations for California's Medi-Cal program.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on Nov 3, 2017, in Sacramento, California.

MARI CANTWELL
Chief Deputy Director, Health Care Programs
California Department of Health Care Services

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XAVIER BECERRA, SBN 118517
Attorney General of California
JULIE WENG-GUTIERREZ, SBN 179277
Senior Assistant Attorney General
R. MATTHEW WISE, SBN 238485
KARLI EISENBERG, SBN 281923
MICHELE L. WONG, SBN 167176
Deputy Attorneys General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-6046
Fax: (916) 324-8853
E-mail: Matthew.Wise@doj.ca.gov
Attorneys for Plaintiff State of California, by and through Attorney General Xavier Becerra

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA,

Plaintiff,

v.

DON J. WRIGHT, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF LABOR; U.S. DEPARTMENT OF LABOR; STEVEN MNUCHIN, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF THE TREASURY; U.S. DEPARTMENT OF THE TREASURY; DOES 1-100,

Defendants.

4:17-cv-05783-KAW

DECLARATION OF LISA IKEMOTO IN SUPPORT OF STATE OF CALIFORNIA'S MOTION FOR PRELIMINARY INJUNCTION

I, Lisa Ikemoto, declare:

1. I am a Professor at UC Davis School of Law, and specialize in health care law and reproductive health and rights. I earned a J.D. at UC Davis School of Law (1987), and an LL.M. from Columbia Law School (1989). I am now a Martin Luther King, Jr. Professor at UC Davis School of Law, with faculty affiliate status in the Health Systems Bioethics Program, the Masters in Public Health Program, and the Feminist Research Institute. I have taught and researched health care law, bioethics, and reproductive rights since 1989. My work focuses on women's reproductive health and rights, including the effects of religious doctrine on women's health; health care disparities; and reproductive technology use.

2. I serve and have served as board member or advisor for a number of women's rights and health organizations, including the California Women's Law Center, National Asian Pacific American Women's Forum, and Forward Together. I currently serve as a member of the Guttmacher Institute Board of Directors (2014 - present) and as an Advisory Committee member for If/When/How (2011- present).

3. Since 2010, I have closely followed the promulgation of the rules addressing contraceptive coverage under the ACA. I have read and am familiar with the two interim final rules (IFRs) issued on October 6, 2017.

4. Upon reviewing the IFRs, I gathered data to determine their impacts on California women. Specifically, I reviewed and assessed the impact of the IFRs on employees and their dependents receiving coverage from self-insured plans in California.

The IFRs authorize private employers to use the broadly expanded religious and moral exemptions for any or all of the FDA approved methods of contraception, including sterilization procedures and patient education and counseling for women with reproductive capacity. The California Women's Contraception Equity Act recognizes that access to these services are part of comprehensive health care for women and will preserve access to these essential services for women in insured plans. Cal. Health & Saf. Code § 1367.25. Because the state benefit mandate does not apply to self-funded plans, the IFRs place women participants and dependents in self-

funded employer health benefit plans at risk of losing coverage for contraceptive, sterilization, and education and counseling services.

The scope of the risk is significant. Nationally, the majority – 61% of health plans are self-insured. KAISER FAMILY FOUND., *2016 Employer Health Benefits Survey* at 8 (Sept. 14, 2016), http://files.kff.org/attachment/Report-Employer-Health-Benefits-2016-Annual-Survey. In California, between 3.7 million and 6.6 million employees and dependents were enrolled in self-insured plans. CAL. HEALTH BENEFITS REV. PROGRAM, ESTIMATES OF SOURCES OF HEALTH INSURANCE IN CALIFORNIA FOR 2018 at 4 (2017), http://chbrp.com/Estimates%20of%20Sources%202018%20Final%2003142017.pdf; CALIFORNIA HEALTH CARE FOUND., *The Private Insurance Market in California* (2015), http://www.chcf.org/publications/2015/02/data-viz-health-plans. The majority of women have health benefits through employment-based plans. Laurie Sobel, Adara Beamesderfer, & Alina Salganicoff, *Issue Brief: Private Insurance Coverage of Contraception*, p. 2, KAISER FAMILY FOUND.: WOMEN'S HEALTH POL'Y 2 (Dec. 7, 2016), http://files.kff.org/attachment/issue-brief-private-insurance-coverage-of-contraception. That suggests that a substantial proportion, if not a majority, of the millions of Californians enrolled in self-insured plans are women. In addition, self-funded plans are more commonly used by large employers. The percentage of workers covered by self-funded plans increases with the size of the employer. For example, in 2016, 50% of employees of firms with 200-999 workers were enrolled in self-funded plans, while 94% of employees of firms with 5,000 or more workers were enrolled in self-funded plans. KAISER FAMILY FOUND., 2016 *Health Benefits Survey*, *supra*. If only a few large employers with self-funded plans use the religious and moral exemptions, the number of employees affected may still be in thousands, if not 10,000s. It is that group of Californians who are at risk of losing access to comprehensive health care if employers are able to use the IFRs' exemptions. Working class women will be most vulnerable because they are least likely to have the disposable income necessary to pay out of pocket.

While many choose jobs with health benefits over those that do not, employees do not expect employers' religious beliefs to affect the scope of health benefits. Nor do most employees

choose jobs based on employers' religious beliefs. Civil rights laws, including Title VII, which prohibits an employer from discriminating against employees who have different religious beliefs than the employer's, have established a norm that employer religious beliefs are not supposed to affect the workplace. The IFRs will allow employers to impose their beliefs on employees through the exemptions.

5. I also reviewed research, including quantitative and qualitative data, and analysis, on barriers to contraceptive access, the effects of disruption and other barriers to contraceptive use. The research shows that the IFRs will create barriers to access that harm women.

Loss of coverage will create an access barrier to the contraceptive methods most women use. The pill, female sterilization, the condom, and the IUD, a form of long acting reversible contraception (LARC), are the four most commonly used methods of contraception. *Id*. at 1; Megan L. Kavanaugh & Jenna Jerman, *Contraceptive Method Use in the United States: Trends and Characteristics Between 2008, 2012 and 2014*, CONTRACEPTION at 7 (2017). The pill, sterilization, the IUD and implantable rods are also among the most effective forms of birth control. U.S. FOOD & DRUG ADMIN., BIRTH CONTROL GUIDE, (last visited Oct. 19, 2017), https://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM517406.pdf. A recent study shows that while the proportion of women who used a contraceptive method did not significantly change between 2008 and 2014, the types of contraceptive methods that women used during that period changed significantly. Notably, women's use of LARCs more than doubled by 2014, while female and male sterilization use declined the most, compared to other methods. Kavanaugh & Jerman, *Contraceptive Method Use in the United States*, *supra*, at 6. These results are consistent with those in a study conducted before implementation of the ACA's contraceptive coverage requirement. A 2007 study showed that "women who were uninsured were 30% less likely than women with some form of health insurance to use prescription contraceptives." Kelly R. Culwell & Joe Feinglass, *The Association of Health Insurance with Use of Prescription Contraceptives*, 39 PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH 226, 227 (2007). These studies show that insurance coverage enables women to choose methods that are more effective.

The IFRs will create barriers to access to the most common and preferred methods of contraception. The IFRs authorize employers to claim an exemption for some or all of the contraception methods and surgical procedures. As *Burwell v. Hobby Lobby* showed, some employers object to methods they believe interfere with conception, including IUDs. Catholic doctrine prohibits use of all eighteen FDA-approved contraceptive methods. If employers are able to use the IFRs, the methods most women use will be excluded from coverage.

A self-funded employer's decision to exempt contraceptive services will impact all women who have been obtaining contraception through the plan. Exemptions disrupt the seamless provision of care that is necessary for effective family planning. As noted, cost is a substantial barrier to contraceptive use, as well as to effective contraceptive use. A recent Guttmacher Policy Review points to a well-powered study based on claims data that found, "women were less likely to stop using the pill once costs were removed in the wake of the federal contraceptive coverage guarantee." Adam Sonfield, *What is at Stake with the Federal Contraceptive Coverage Guarantee?*, 20 GUTTMACHER POLICY REVIEW 8, 10 (2017), citing Lydia E. Pace, Stacie B. Dusetzina & Nancy L. Keating, *Early Impact of the Affordable Care Act on Oral Contraceptive Cost Sharing, Discontinuation, and Nonadherence*, 35 HEALTH AFFAIRS 1616 (2016). Loss of coverage adds barriers to access to education and counseling about family planning, and to contraceptives in a number of ways. The American College of Obstetricians and Gynecologists has identified knowledge deficits, exclusions in contraceptive equity laws, high out of pocket costs, deductibles, and co-payments for contraception (especially for LARCs), insurance limits on refills that prevent timely use of contraception, and medical practices that require women to go through additional steps as barriers to contraceptive access. COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, COMMITTEE OPINION: ACCESS TO CONTRACEPTION, AM. CONG. OF OBSTETRICIANS & GYNECOLOGISTS (2015), https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Access-to-Contraception (reaff'd 2017). Women who lose contraceptive coverage will face many of these barriers. Loss of coverage will impose the need to obtain funding, change providers, decide

whether to switch to a less expensive contraceptive method, switch from a pharmacy to a family planning clinic, etc. Disruption of services, even if temporary, constitutes a barrier to access.

6. I reviewed legal and health research to determine the effects of contraceptive access on women's ability to participate in and contribute to society. The research shows that contraceptive access has empowered women and alleviated the burden of family planning placed on women.

Access to contraception is part of comprehensive health care. In fact, the American Public Health Association (APHA) "supports the universal right to contraception access in the United States and internationally." In 2015, the APHA adopted a policy that "urges all governments, health providers, and health funding systems to ensure the right to contraception without exceptions, through services including comprehensive evidence-based counseling, language translation, and referrals as needed." AM. PUB. HEALTH ASSOC., *Universal Access to Contraception* (Nov. 3, 2015), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/12/17/09/14/universal-access-to-contraception (Policy Number 20153).

Failure to cover some or all prescription contraceptives discriminates on the basis of gender. The IFRs authorize employers to claim exemption from coverage of eighteen FDA approved contraceptives. All eighteen are contraceptive methods that only women use. In 2000, the U.S. Equal Employment Opportunity Commission determined that an employer providing coverage for prescription drugs except prescription contraceptives violated Title VII of the Civil Rights Act of 1964. The resulting order stated not only that the employer must cover the expenses of prescription contraceptives to the same extent it covered other prescription drugs, devices, and preventive care, but also that the employer must cover the full range of prescription contraceptives. U.S. EQUAL EMP'T OPPORTUNITY COMM'N, DECISION ON COVERAGE OF CONTRACEPTION (Dec. 14, 2000), https://www.eeoc.gov/policy/docs/decision-contraception.html. Twenty-eight states have addressed the concerns about gender equality and access to comprehensive health care with state benefit mandates, including the California Womens' Contraception Equity Act. GUTTMACHER INST., STATE LAWS AND POLICIES: INSURANCE

COVERAGE OF CONTRACEPTIVES (as of October 1, 2017), https://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives.

Access to contraceptives and other family planning services is key to women's participation in society and to gender equality. In 2013, the Guttmacher Institute published a major report that carefully reviewed and synthesized research documenting the ways and extent to which women's contraceptive access and use has enabled greater participation in postsecondary education and employment, increased earning power, and economic stability. Studies focusing on young women in the 1960s and 1970s showed the effects of the advent of the pill. Several studies showed that access to effective contraception was a "significant factor behind greater numbers of women investing in higher education." A study on young women's college enrollment in the 1970s revealed a 12% increase in the likelihood of college enrollment among young women with access to the pill, compared to those without, and a 35% lower dropout rate among women with access to the pill, compared to those without. Adam Sonfield et al., THE SOCIAL AND ECONOMIC BENEFITS OF WOMEN'S ABILITY TO DETERMINE WHETHER AND WHEN TO HAVE CHILDREN, GUTTMACHER INST. 7 (March 2013), https://www.guttmacher.org/sites/default/files/report_pdf/social-economic-benefits.pdf. Studies on workforce participation have produced strong evidence that access to the pill "was a driving force behind the societal shift to significantly more young women participating in the paid labor force, including professional occupations." *Id*. at 12. More recent studies show that contraceptive access has "significantly contributed to increasing women's earning power and to decreasing the gender gap in pay," which persists. *Id*. at 17.

Access to contraceptives alleviate the burden placed on women for family planning. Women bear burden of preventing pregnancy and controlling the timing of bearing children. Social norms that allocate the responsibility for implementing family planning decisions make the unequal allocation of responsibility seem natural. Katrina Kimport, *More Than a Physical Burden: Women's Mental and Emotional Work in Preventing Pregnancy*, J. SEX RESEARCH 1 (2017). Contraceptive access alleviates the burden of implementing pregnancy prevention or timing. For the women affected by the IFRs, that burden will increase. A recent study has found

that family planning counseling can address the ways in which the burdens of family planning disproportionately affect women. *Id*. at 8. The elimination of coverage for counseling services will prevent the equalization of the responsibilities for family planning.

7. Based on over twenty-years of research on women's health and rights, my review of the IFRs, and a review of data and other research conducted for this Declaration, I conclude that the IFRs will have significant impact on women in California by imposing barriers to contraceptive access for women enrolled in self-insured plans sponsored by employers the IFRs authorize to exclude contraceptive and family planning services coverage; by exposing women to risks and attendant effects of unintended pregnancy; and by increasing risks to participation in higher education, career attainment, and economic stability. The IFRs authorize employers to impose reproductive control over women enrolled in self-funded plans.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on October 19, 2017, in Davis, California.

Lisa Ikemoto
Martin Luther King, Jr. Professor
UC Davis School of Law

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA; STATE OF NEW YORK; STATE OF DELAWARE; COMMONWEALTH OF VIRGINIA, Plaintiffs, **v.** **DON J. WRIGHT, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF LABOR; U.S. DEPARTMENT OF LABOR; STEVEN MNUCHIN, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF THE TREASURY; U.S. DEPARTMENT OF THE TREASURY; DOES 1-100,** Defendants.	4:17-cv-05783-KAW **DECLARATION OF TRINIDAD NAVARRO, INSURANCE COMMISSIONER OF DELAWARE, IN SUPPORT OF COMPLAINT FOR DECLARATIVE AND INJUNCTIVE RELIEF**

I, Trinidad Navarro, declare and say as follows:

1. I am the elected Insurance Commissioner for the State of Delaware. I have served in this capacity since January 3, 2017. The facts stated herein are of my own personal knowledge or are based on information and belief. If called, I could and would competently testify to them.

2. As the elected Insurance Commissioner for the State of Delaware, I oversee the Delaware Department of Insurance (the "DDOI"). The DDOI has regulatory authority and jurisdiction over health insurers and health insurance coverage in Delaware. The DDOI does not, however, have jurisdiction over health plans issued by self-insured employers, which are governed by the Employee Retirement Income Security Act ("ERISA") and regulated by the U.S. Department of Labor, Employee Benefits Security Administration.

3. Nearly one-third of all Delawareans, over 300,000 individuals, however, are covered under self-insured plans.

4. I am familiar with the new Interim Final Rules that affect contraceptive coverage (the IFRs"), which are the basis for the Amended Complaint. As drafted, the IFRs would allow any employer or insurer that claims a religious or moral objection to providing contraceptive coverage - a coverage exemption. The IFRs further remove the mandatory accommodation for continued coverage for women who cannot obtain birth control through their employer. These expanded exemptions together effectively make contraceptive coverage optional.

5. Delawareans have a constitutionally guaranteed right to privacy. The Interim Final Rules ("IFRs") threaten the ability of women to exercise their right to privacy.

6. As Delaware Insurance Commissioner, I am responsible for enforcing state insurance laws, which have incorporated the Patient Protection and Affordable Care Act's ("ACA") mandate that all health insurance coverage include coverage for essential health benefits, including contraceptive coverage with no cost-sharing. 18 *Del. C.* §§ 3571M and 3610.

7. Since the implementation of the ACA mandates, over 171,575 Delaware women have benefited from preventative services coverage with no cost-sharing, including FDA-approved contraceptives, in non-grandfathered plans.[1]

8. In addition to the ACA mandates requiring access to contraceptive coverage with no cost sharing, the Delaware General Assembly passed in 2000 legislation requiring all group and blanket health insurance policies delivered or issued for delivery in the State, and which provide coverage for outpatient prescription drugs, to provide coverage for all FDA approved prescription contraceptive drugs and devices and other outpatient services related to the use of such drugs and services (the "Delaware Contraceptive Equity Act"). *See* 18 *Del. C.* § 3559.

9. While non-grandfathered plans and individual insurance policies are required to provide contraceptive coverage at no cost to the insureds, grandfathered plans and policies, including those for which the Delaware Contraceptive Equity Act apply, can impose cost sharing if "such additional cost sharing is imposed for access to health-care practitioners for other types of healthcare." 18 *Del. C.* § 3559(b).

[1] https://aspe.hhs.gov/system/files/pdf/139221/The%20Affordable%20Care%20Act%20is%20Improving%20Access%20to%20Preventive%20Services%20for%20Millions%20of%20Americans.pdf

10. Subsection (d) of the Delaware Contraceptive Equity Act in Delaware includes a religious employer exemption as follows: "[a] religious employer may request and an entity subject to this section shall grant an exclusion from coverage under the policy, plan or contract for the coverage required under subsection (b) of this section if the required coverage conflicts with the religious organization's bona fide religious beliefs and practices. A religious employer that obtains an exclusion under this subsection shall provide its employees reasonable and timely notice of the exclusion."

11. The Delaware Contraceptive Equity Act will provide some protection to Delawareans in maintaining their contraceptive coverage in the event of changes to federal law. However, the Act does not guarantee free access to contraceptive coverage nor does it apply to individual policies. Additionally, because the DDOI does not have regulatory authority over self-insured plans, the Act does not protect the nearly one-third of Delawareans covered under these plans. Many people whose health coverage is through employers that self-insure may not realize that because their coverage is self-funded, the coverage is not subject to state law protections, including the contraceptive mandate.

12. Those at risk of losing access to contraceptives under the IFRs include not only female employees of self-funded employers, but also the female dependents of employees covered by such plans.

13. In 2010, Delaware had the highest unintended pregnancy rate in the country, at a rate of 62 of such pregnancies per 1,000 women aged 15-44.[2] If the IFRs are not declared invalid, some women covered by self-insured employer plans may quickly lose access to contraceptives and women covered by other employer plans may lose free access to contraceptives, which could result in an increase in unintended pregnancies.

14. Some women who lose access to coverage for contraceptives due to the IFRs will likely seek contraceptive services from the family planning programs offered by the Delaware Division of Public Health. However, in some instances these services come at a cost to the women seeking these services and eligibility is limited to low-income Delawareans with incomes less than 250% of the federal poverty level. Women with incomes above 250% of the federal poverty level who do not seek services from the Division of Public Health will be faced with the burden of bearing the full cost of contraceptive services and products if the IFRs are not stricken.

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[2] https://www.guttmacher.org/fact-sheet/state-facts-publicly-funded-family-planning-services-delaware

I declare under penalty of perjury that the foregoing is true and correct and if called as a witness, I would competently testify to the statements above.

By: _____
Trinidad Navarro
Delaware Insurance Commissioner
Date: October 20, 2017

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA; STATE OF NEW YORK; STATE OF DELAWARE; COMMONWEALTH OF VIRGINIA, Plaintiffs, **v.** **DON J. WRIGHT, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF LABOR; U.S. DEPARTMENT OF LABOR; STEVEN MNUCHIN, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF THE TREASURY; U.S. DEPARTMENT OF THE TREASURY; DOES 1-100,** Defendants.	4:17-cv-05783-KAW **DECLARATION OF RUTH LYTLE-BARNABY, IN SUPPORT OF COMPLAINT FOR DECLARATIVE AND INJUNCTIVE RELIEF**

I, Ruth Lytle-Barnaby, MSW, declare and state as follows:

1. I am the President and CEO for Planned Parenthood of Delaware (PPDE) and the President and CEO for Planned Parenthood Advocacy Fund of Delaware (PPAFD). I represent the three health centers and mobile care we provide in Delaware. I have been the President and CEO of PPDE and PPAFD since 2012. Before that I spent almost twenty-five years working healthcare in management and executive roles.
2. This declaration is based on my personal knowledge, my review of PPDE's and PPAFD's business records, and the knowledge I have acquired in the course of my five years of service and duties at Planned Parenthood. If called and sworn as a witness, I could and would testify competently to the information in this declaration.

3. The mission of PPDE and PPAFD is to actively promote reproductive health and responsible sexual behavior through the provision of comprehensive high quality education, counseling and medical services. Delaware operates three health centers, provides care at mobile sites and will serve more than 8,000 unique patients each year.
4. As discussed more fully below, the two interim final rules that the U.S. Health and Human Services Department, in conjunction with the U.S. Department of Labor and U.S. Department of Treasury, issued on October 6, 2017 (IFRs) would have devastating consequences for the women in Delaware who rely on Planned Parenthood for a variety of reproductive health and family planning care. The IFRs would also have a devastating impact on the State of Delaware, which reimburses Planned Parenthood affiliates for those patients' care through a combination of state and federal funding. Planned Parenthood provides more than 12,000 patient visits annually, more than 30% of the Delaware women of reproductive age who are in need of publicly funded family planning services. 6,085 (51%) of those visits receive care through programs reimbursed by the State.

I. EMPLOYMENT AND EDUCATION BACKGROUND

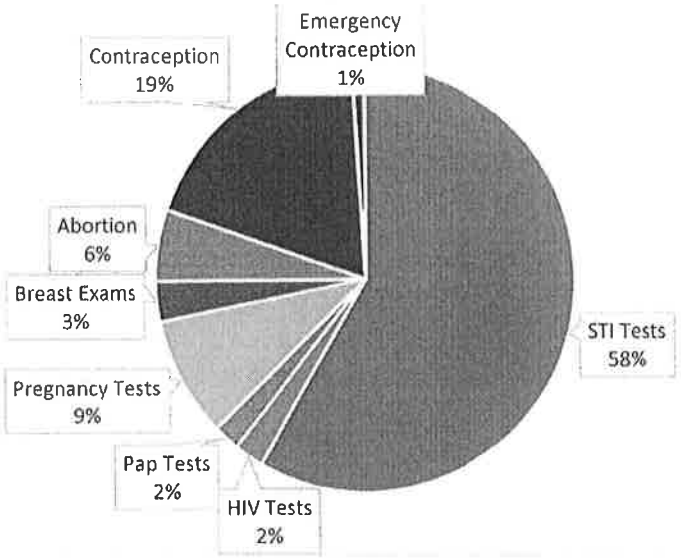
5. I received my Bachelors in Social Work (BSW) from East Carolina University in 1982. I then earned my Masters in Social Work (MSW) from the Washington University in St. Louis in 1984. In 1998, I completed a fellowship with The Health Forum on Creating Healthier Communities.
6. My career includes working as a psychotherapist for children and adolescents, creating community partnerships to address senior issues, healthy kids, obesity prevention, prenatal, family education and motor vehicle safety. I have also run a Foundation and Research Department before coming to Planned Parenthood. Much of my work has utilized the social determinants of health.
7. PPDE is the Planned Parenthood affiliate for the State of Delaware. It provides services to approximately 8,000 unique patients annually through three clinics and mobile care located at Wesley College and Delaware State University. The care for 28% of our patients is reimbursed through the State's Medicaid program and 16% is reimbursed by Title X.

II. ORGANIZATION AND AFFILIATION

8. PPAFD is a 501(c)(4) organization that leads the state-wide public policy and advocacy work on behalf of Planned Parenthood of Delaware (PPDE).
9. PPDE is a Delaware non-profit 501(c)(3) organization that works to provide reproductive health care services in settings that preserve and protect the essential privacy and rights of each individual.
10. PPDE has its own Board of Directors, budget, management and staff. It is responsible for delivering health care services in a distinct geographic region. This affiliate provides sexual education and reproductive health care across Delaware through three health centers. In fiscal year 2017, these affiliates served more than 8,000 unique patients; 73% were at or below 200% of the federal poverty line. PPDE affiliates provided contraception to nearly 5,600 patients, conducted 3,000 pregnancy tests, and provided over 20,000 tests and treatments of sexually transmitted infections. PPDE also provided sexual health education programs to 3,344 youth in Delaware in 2016.

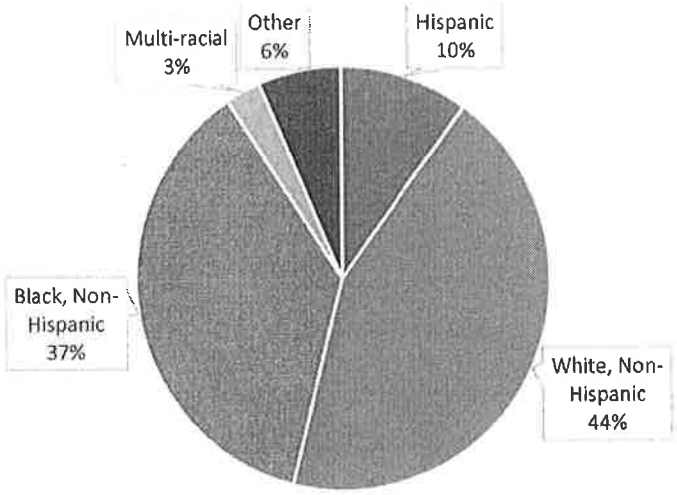
III. PLANNED PARENTHOOD'S ROLE IN PROMOTING PUBLIC HEALTH IN DELAWARE

11. Planned Parenthood operates three health centers in Delaware. These health centers are located in Wilmington, Newark and Dover, Delaware. Mobile care is also provided in Kent County, at Wesley College and Delaware State University.
12. Planned Parenthood provides reproductive health care services as a "one stop shop". This means that a patient is able to get an office visit, most relevant lab tests and any needed drugs or supplies at one location without having to travel to a pharmacy or lab testing facility. This service is particularly important for the low income patients we serve who usually do not have the time, money or resources to take additional time off from work or school or the ability to arrange for childcare. It also increases the likelihood that patients will get their tests completed and take the drugs they are prescribed.
13. PPDE offers education and counseling on reproductive health for both men and women; the provision of birth control, including emergency contraception; testing of HIV, gonorrhea, chlamydia and the HPV virus; STI treatment; pregnancy testing and services; breast and cervical cancer screenings; colposcopy, LEEP, and safe and legal abortion. In addition, all sites offer PEP and PreP for HIV prevention. Two centers just started offering prenatal care. This is an overview of the primary services we offer in Delaware:



14. 10/1/16 – 9/30/17, Planned Parenthood saw over 8,000 unique patients in almost 12,000 appointments. In fiscal year 2017 we served Delaware with:
    a. Contraception to nearly 5,600 patients
    b. More than 300 emergency contraception tests
    c. 3,000 pregnancy tests
    d. Almost 700 cervical cancer screenings
    e. More than 1,000 breast cancer exams
    f. Over 20,000 tests and treatments for sexually transmitted infections
    g. Sexual health education programs reaching 3,344 youth.
15. Planned Parenthood primarily serves low income patients in Delaware who have limited access to health care services.
    a. Approximately 86% of our patients are women, almost all of those are in the prime reproductive age range of 18 to 39;
    b. 73% are below 200% of the federal poverty level ($24,120 for one person). Of those, 62% are below 138% of the federal poverty level ($16,643 for one person);
    c. The demographics of our patients roughly mirror the demographics of Delaware: 44% are white, 10% are Hispanic, 37% are Black; 3% are multi-

racial and 6% other or unknown.



d. Some of our patients are immigrants, and are undocumented. Many speak languages other than English. All health centers have telephone access to translators in 250 languages.

e. We also serve a number of special-needs populations, including people with physical, mental or other social challenges; migrant workers; homeless people; people who experience trauma or domestic violence; people with physical disabilities; patients with limited English skills; and lesbian, gay, bisexual, transgender people. We have implemented a variety of programs to extend access to these populations and to assure delivery of care that is culturally sensitive and appropriate.

16. Planned Parenthood operates its health centers in medically underserved areas as designated by HRSA. For example, Planned Parenthood operates a health center in Dover (Kent County), with a 12.9% poverty rate.

17. Planned Parenthood clinics are staffed with experienced practitioners at multiple levels. We employ physicians, advanced practice clinicians (physicians' assistants, nurse practitioners, certified nurse midwives, registered nurses) and medical assistants. Each operates within their particular, authorized scope of practice so that health care services are delivered as efficiently and cost-effectively as possible.

18. Patients come to Planned Parenthood for the accurate, nonjudgmental, compassionate and confidential care and information they need and deserve. Providers are trained to be culturally competent, which is essential in a State with such a diverse patient base.
19. Planned Parenthood of Delaware also engages in advocacy and public education activities. In 2016, our sexual health education programs reached more than 3300 youth.

IV. MEDICAID/TITLE X

20. Planned Parenthood of Delaware is engaged in a unique public/private venture with Upstream USA to decrease the number of unplanned pregnancies by increasing overall access to all forms of contraception for all Delawareans.
21. Approximately 24% of Planned Parenthood's patients receive their health care through DMMA. 22% are enrolled in the Managed Care Program, described in greater detail below. 2% receive their care through fee-for-service. Delaware reimburses Planned Parenthood for the care it provides patients through these programs. Pursuant to Delaware's State Medicaid Plan, the federal government is responsible for covering a portion of the care, and the State of Delaware covers the remainder. For the majority of the care Planned Parenthood of Delaware provides through Medicaid, the federal government contributes .90 cents, while the state contributes .10 cents, for every dollar spent. Except in very rare circumstances, the State of Delaware does not cover the cost of abortions.
22. Planned Parenthood of Delaware participates in the Title X program. Title X provides comprehensive reproductive health care (minus abortion services) for persons without insurance based upon a sliding scale. This program is administered through the Delaware Department of Health and Social Services. 64% of PPDE's patients participate in this program.
23. Family planning, and the consistent use of contraception, is the most cost effective way to reduce unintended pregnancies.[1] For every 1000 unintended pregnancies, 42% will result

[1] Bixby Center for Global Reproductive Health, UCSF, *Cost-Benefit Analysis of the California Family PACT Program for Calendar Year 2007*, at 6-7, 20 (April 2010).

in live births, 13% in miscarriages, and 45% in abortion[2]. Thus, reducing unintended pregnancies reduces expenses due to fewer delivery, miscarriage or abortion costs.

24. In Delaware, 71% of unplanned births are paid for by the State.

25. 99% of sexually active American women 15-44 have used a contraceptive method other than natural family planning. Delaware statistics: In 2014, publically funded family planning helped avert 3,600 unintended pregnancies which would have resulted in 1,700 unplanned births and 1,300 abortions. In 2010, 57% of all pregnancies in Delaware were unintended. In 2014, 50,100 women aged 13-44 were in need of publically funded family planning services. In 2014 family planning centers served 14,900 clients. This met 30% of the need. In 2010, public expenditures for family planning client services in Delaware totaled $7.2 million; this includes $5.6 million through Medicaid and $908,000 through Title X. In 2010, Delaware contributed $693,000.[3]

V. New IFRs

26. I have reviewed and am familiar with the new contraceptive coverage IFRs, 2017-21851 and 2017-21852. Under them, any employer that claims a religious or moral objection to providing contraceptive coverage would be exempt. In addition, the IFRs remove the mandatory accommodation that women who were no longer able to obtain birth control through their employer could take advantage of to ensure continued contraceptive coverage. These expanded exemptions, together, would effectively make contraceptive coverage optional.

27. If their parent's insurance no longer covers contraceptive care, there is a high likelihood young people insured by their parents will come to Planned Parenthood and qualify for Title X. This will increase costs for the State and federal governments.

28. I also believe that Delaware will see an increase in unintended pregnancies as a result of the IFRs. Those women who do not qualify for Title X may not get contraception. Research suggests that the rate of unintended pregnancy in Delaware among those who are not using contraception is 57%.[4] Because 71% of births in Delaware are paid for by the State, the State will have increased costs shouldering the costs of delivery. Finally,

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[2] CHBRP Contraceptive Report, at 30, *citing* Kost K., *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends since 2002* (New York 2015).

[3] Guttmacher Institute

[4] Guttmacher Institute

women who do not qualify for Title X may opt against the most effective forms of birth control, which are more expensive. As a result, they will be at a higher risk of unintended pregnancy.

29. Finally, I anticipate that Planned Parenthood of Delaware will have to increase charitable contributions to our assistance funds to help insured patients with high co-pays or deductibles, or who have lost coverage for contraception, afford birth control.

I declare under penalty of perjury that the foregoing is correct and that this declaration is executed on 20th day of October, 2017, in Wilmington, Delaware.

Ruth Lytle-Barnaby
President and CEO
Planned Parenthood of Delaware and
Planned Parenthood Advocacy Fund of Delaware

XAVIER BECERRA, SBN 118517
Attorney General of California
JULIE WENG-GUTIERREZ, SBN 179277
Senior Assistant Attorney General
R. MATTHEW WISE, SBN 238485
KARLI EISENBERG, SBN 281923
MICHELE L. WONG, SBN 167176
Deputy Attorneys General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-6046
Fax: (916) 324-8853
E-mail: Matthew.Wise@doj.ca.gov
Attorneys for Plaintiff State of California, by and through Attorney General Xavier Becerra

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, STATE OF DELAWARE, STATE OF MARYLAND, STATE OF NEW YORK, STATE OF VIRGINIA, Plaintiffs, **v.** **DON J. WRIGHT, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF LABOR; U.S. DEPARTMENT OF LABOR; STEVEN MNUCHIN, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF THE TREASURY; U.S. DEPARTMENT OF THE TREASURY; DOES 1-100,** Defendants.	4:17-cv-05783-HSG **DECLARATION OF DR. LAWRENCE FINER IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

I, Lawrence Finer, declare as follows:

1. I am the Vice President for Domestic Research at the Guttmacher Institute, where I have worked since 1998. I hold an A.B. in psychology from Harvard University and a Ph.D. in population dynamics from the Johns Hopkins University School of Public Health.

2. The Guttmacher Institute is a private, independent, nonprofit, nonpartisan corporation that advances sexual and reproductive health and rights through an interrelated program of research, policy analysis, and public education. The Institute's overarching goal is to ensure quality sexual and reproductive health for all people worldwide by conducting research according to the highest standards of methodological rigor and promoting evidence-based policies. It produces a wide range of resources on topics pertaining to sexual and reproductive health and publishes two peer-reviewed journals. The information and analysis it generates on reproductive health and rights issues are widely used and cited by researchers, policymakers, the media and advocates across the ideological spectrum.

3. Over the course of more than 20 years, I have designed, executed, and analyzed numerous quantitative and qualitative research studies in the field of reproductive health care and the demographics of and trends in fertility behaviors in the United States. My peer-reviewed research has been published in dozens of articles, including first-authored work in the *New England Journal of Medicine*, the *American Journal of Public Health*, *Obstetrics & Gynecology*, *Contraception*, *Pediatrics*, and many other public health, medical and demographic journals. I have served as principal investigator on multiple competitively funded research grants from the National Institutes of Health. I have given dozens of presentations at meetings and conferences of social science and medical professionals on a variety of reproductive health-related topics. My education, training, responsibilities and publications are set forth in greater detail in my curriculum vitae, a true and correct copy of which is attached as Exhibit A. I submit this declaration as an expert on unintended pregnancy and the demographics of reproductive health behaviors in the United States.

4. I understand that this lawsuit involves a challenge to the federal government's interim final rules ("IFRs") regarding the Affordable Care Act's ("ACA") contraceptive coverage mandate. As noted above and set forth in my attached curriculum vitae, I am the author of numerous studies on demographic trends in unintended pregnancy and disparities in its incidence, and on contraception, including its use, efficacy, and importance for the prevention of unintended pregnancy. I am also familiar with the research literature on the effects of increased and decreased access to various forms of contraception as well as the literature on public family planning programs. In my expert opinion, the IFRs will compromise women's ability to obtain contraceptive methods, services and counseling and, in particular, to consistently use the best methods for them, thus putting them at heightened risk of unintended pregnancy.

Contraception Is Widely Used and the Majority of Women Rely on Numerous Contraceptive Methods for Decades of Their Lives

5. More than 99% of women aged 15–44 who have ever had sexual intercourse have used at least one contraceptive method; this is true across a variety of religious affiliations.[1] Some 61% of all women of reproductive age are currently using a contraceptive method.[2] Among women at risk of an unintended pregnancy (i.e., women aged 15–44 who have had sexual intercourse in the past three months, are not pregnant or trying to conceive, and are not sterile for noncontraceptive reasons), 90% are currently using a contraceptive method.[3]

6. A typical woman in the United States wishing to have only two children will, on average, spend three decades—roughly 90% of her reproductive life—avoiding unintended pregnancy.[4]

[1] Daniels K, Mosher WD and Jones J, Contraceptive methods women have ever used: United States, 1982–2010, *National Health Statistics Reports*, 2013, No. 62, https://www.cdc.gov/nchs/products/nhsr.htm.
[2] Kavanaugh ML and Jerman J, Contraceptive method use in the United States: trends and characteristics between 2008, 2012 and 2014, *Contraception*, 2017, https://www.guttmacher.org/article/2017/10/contraceptive-method-use-united-states-trends-and-characteristics-between-2008-2012.
[3] Kavanaugh ML and Jerman J, Contraceptive method use in the United States: trends and characteristics between 2008, 2012 and 2014, *Contraception*, 2017, https://www.guttmacher.org/article/2017/10/contraceptive-method-use-united-states-trends-and-characteristics-between-2008-2012.
[4] Sonfield A, Hasstedt K and Gold RB, *Moving Forward: Family Planning in the Era of Health Reform*, New York: Guttmacher Institute, 2014, https://www.guttmacher.org/report/moving-forward-family-planning-era-health-reform.

7. Women and couples rely on a wide range of contraceptive methods: In 2014, 25% of female contraceptive users relied on oral contraceptives and 15% on condoms as their most effective method. That means that six in 10 contraceptive users relied on other methods: female or male sterilization; hormonal or copper intrauterine devices (IUDs); hormonal methods including the injectable, the ring, the patch and the implant; and behavioral methods, such as withdrawal and fertility awareness methods.[5]

8. Most women rely on multiple methods over the course of their reproductive lives, with 86% having used three or more methods by their early 40s.[6] Sometimes, women and couples may try out different methods to find one that they can use consistently or that minimizes side effects. Other times, they may switch from method to method—such as from condoms to oral contraceptives to sterilization—as their relationships, life circumstances and family goals evolve.

9. Many people use two or more methods at once: 17% of female contraceptive users did so the last time they had sex.[7] For example, they may use condoms to prevent STIs and an IUD for the most reliable prevention of pregnancy. Or they may use multiple methods simultaneously—for instance, condoms, withdrawal and oral contraceptives—to provide extra pregnancy protection.

Women Need Access to the Full Range of Contraceptive Options to Most Effectively Avoid Unintended Pregnancies

10. Using any method of contraception greatly reduces a woman's risk of unintended pregnancy. Sexually active couples using no method of contraception have a roughly 85% chance

[5] Kavanaugh ML and Jerman J, Contraceptive method use in the United States: trends and characteristics between 2008, 2012 and 2014, *Contraception*, 2017, https://www.guttmacher.org/article/2017/10/contraceptive-method-use-united-states-trends-and-characteristics-between-2008-2012

[6] Daniels K, Mosher WD and Jones J, Contraceptive methods women have ever used: United States, 1982–2010, *National Health Statistics Reports*, 2013, No. 62, https://www.cdc.gov/nchs/products/nhsr.htm.

[7] Kavanaugh ML and Jerman J, Concurrent multiple methods of contraception in the United States, poster presented at the North American Forum on Family Planning, Atlanta, Oct. 14–16, 2017.

of experiencing a pregnancy in a one-year period, while the risk for those using a contraceptive method ranges from 0.05% to 28%.[8,9]

11. All new contraceptive drugs and devices (just like other drugs and devices) must receive approval from the U.S. Food and Drug Administration and must be shown to be effective through rigorous scientific testing. Thus, the federal government itself provides the oversight to ensure that contraception is effective in preventing pregnancy.

12. The government's effort to imply in the IFRs that there is doubt about whether contraception reduces the risk of unintended pregnancy is simply unfounded, as the data above illustrate. Its assertions to the contrary are flawed. For example, the government argues, "In the longer term—from 1972 through 2002—while the percentage of sexually experienced women who had ever used some form of contraception rose to 98 percent, unintended pregnancy rates in the Unites States rose from 35.4 percent to 49 percent."[10]

13. However, the government's assertion that unintended pregnancy rates rose between 1972 and 2002 is incorrect and based on faulty calculations and an inappropriate comparison. First, the numbers cited (35.4% and 49%) are the *percentage* of all pregnancies that were unintended, not the unintended pregnancy *rate*, which is the appropriate indicator for assessing trends in unintended pregnancy because it is not affected by changes in the incidence of *intended* pregnancy. Second, the 1972 figure includes only *births* (not all pregnancies), and then only those births that were to married women.[11] Births to unmarried women and all abortions are excluded; the proportion of both of these that were unintended were significantly higher, so excluding them results in an artificially low percentage. The 2002 figure, on the other hand,

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[8] Sundaram A et al., Contraceptive failure in the United States: estimates from the 2006-2010 National Survey of Family Growth, *Perspectives on Sexual and Reproductive Health*, 2017, 49(1):7–16, https://www.guttmacher.org/journals/psrh/2017/02/contraceptive-failure-united-states-estimates-2006-2010-national-survey-family.

[9] Trussell J, Contraceptive efficacy, in: Hatcher RA et al., eds., *Contraceptive Technology*, 20th ed., New York: Ardent Media, 2011, pp. 779–863.

[10] Department of the Treasury, Department of Labor and Department of Health and Human Services, Religious exemptions and accommodations for coverage of certain preventive services under the Affordable Care Act, *Federal Register*, 82(197):47838–47862, https://www.gpo.gov/fdsys/pkg/FR-2017-10-13/pdf/2017-21852.pdf.

[11] Weller RH and Heuser RL, Wanted and unwanted childbearing in the United States: 1968, 1969, and 1972 National Natality Surveys, *Vital and Health Statistics*, 1978, No. 32.

includes all pregnancies to all women. An appropriate comparison of rates based on pregnancies and on all women in the population shows a clear decline in the rate: In 1971, there were an estimated 2.041 million unintended pregnancies (including births and abortions, but excluding miscarriages),[12] and 43.6 million women of reproductive age (15–44),[13] for an unintended pregnancy rate (excluding miscarriages) of 47 per 1,000 women. By contrast, in 2011, the unintended pregnancy rate *including* miscarriages was 45 per 1,000.[14] Even when including miscarriages in the later rate, it is lower than the earlier rate; because miscarriages typically represent about 14% of all pregnancies,[15] excluding them from the 2011 figure for comparability would result in a rate of about 38 per 1,000, substantially lower than the 1971 rate.

14. Although using any method of contraception is more effective in preventing pregnancy than not using a method at all, having access to a *limited* set of methods is far different than a woman being able to choose from among the full range of methods to find the *best* methods for her at a given point in her life.

15. One important consideration for most women in a choosing a contraceptive method is how well a method works for an individual woman to prevent pregnancy.[16] IUDs and implants, for example, are effective for years after they are inserted by a health care provider, and do not require women using them to think about contraception on a day-to-day basis.[17] By contrast, birth control pills must be taken every day, at approximately the same time. Nearly half of abortion patients who were users of birth control pills reported that they had forgotten to take their pills, and another quarter reported a lack of ready access to their pills (16% were away from

[12] Tietze C, Unintended pregnancies in the United States, 1970–1972, *Family Planning Perspectives,* 1979, 11(3):186–188.
[13] National Center for Health Statistics, Centers for Disease Control and Prevention, Population by age groups, race, and sex for 1960–1997, no date, https://www.cdc.gov/nchs/data/statab/pop6097.pdf.
[14] Finer LB and Zolna MR, Declines in unintended pregnancy in the United States, 2008–2011, *New England Journal of Medicine*, 2016, 374(9):843–852.
[15] Finer LB and Henshaw SK, Disparities in rates of unintended pregnancy in the United States, 1994 and 2001, *Perspectives on Sexual and Reproductive Health*, 2006, 38(2):90–96, https://www.guttmacher.org/journals/psrh/2006/disparities-rates-unintended-pregnancy-united-states-1994-and-2001.
[16] Lessard LN et al., Contraceptive features preferred by women at high risk of unintended pregnancy, *Perspectives on Sexual and Reproductive Health*, 2012, 44(2):194–200.
[17] Winner B et al., Effectiveness of long-acting reversible contraception, *New England Journal of Medicine*, 366(21):1998–2007.

their pills and 10% ran out).[18] Methods of contraception designed to be used during intercourse, such as condoms or spermicide, must be available, accessible, remembered, and used properly each time intercourse occurs.

16. Beyond effectiveness, there are many other features that people say are important to them when choosing a contraceptive method.[19] These include concerns about and past experience with side effects, drug interactions or hormones; affordability and accessibility; how frequently they expect to have sex; their perceived risk of HIV and other STIs; the ability to use the method confidentially or without needing to involve their partner; and potential effects on sexual enjoyment and spontaneity. For example, methods such as male condoms, fertility awareness and withdrawal require the active and effective participation of male partners. By contrast, methods such as IUDs, implants, and oral contraceptives can be more reliably used by the woman alone in advance of intercourse.[20]

17. Being able to select the methods that best fulfill a woman's needs and priorities is important to ensuring she is satisfied with her chosen methods. Women who are satisfied with their current contraceptive methods are more likely to use them consistently and correctly. For example, one study found that 30% of neutral or dissatisfied users had a temporal gap in use, compared with 12% of completely satisfied users.[21] Similarly, 35% of satisfied oral contraceptive users had skipped at least one pill in the past three months, compared with 48% of dissatisfied users.[22]

[18] Jones RK, Darroch JE and Henshaw SK, Contraceptive use among U.S. women having abortions in 2000–2001, *Perspectives on Sexual and Reproductive Health*, 2002, 34(6): 294–303, https://www.guttmacher.org/journals/psrh/2002/11/contraceptive-use-among-us-women-having-abortions-2000-2001.

[19] Lessard LN et al., Contraceptive features preferred by women at high risk of unintended pregnancy, *Perspectives on Sexual and Reproductive Health*, 2012, 44(2):194–200.

[20] Bailey MJ, More power to the pill: the impact of contraceptive freedom on women's life cycle labor supply, *Quarterly Journal of Economics*, 2006, 121(1): 289–320, https://academic.oup.com/qje/article-abstract/121/1/289/1849021?redirectedFrom=fulltext.

[21] Guttmacher Institute, Improving contraceptive use in the United States, *In Brief*, New York: Guttmacher Institute, 2008, https://www.guttmacher.org/report/improving-contraceptive-use-united-states.

[22] Guttmacher Institute, Improving contraceptive use in the United States, *In Brief*, New York: Guttmacher Institute, 2008, https://www.guttmacher.org/report/improving-contraceptive-use-united-states.

18. Consistent contraceptive use helps women and couples prevent unwanted pregnancies and plan and space those they do want. The two-thirds of U.S. women (68%) at risk of unintended pregnancy who use contraceptives consistently and correctly throughout the course of any given year account for only 5% of all unintended pregnancies. In contrast, the 18% of women at risk who use contraceptives but do so inconsistently account for 41% of unintended pregnancies, and the 14% of women at risk who do not use contraceptives at all or have a gap in use of one month or longer account for 54% of unintended pregnancies.[23]

19. In summary, the ability to choose from among the full range of contraceptive methods encourages consistent and effective contraceptive use, thereby helping women to avoid unintended pregnancies and to time and space wanted pregnancies.

Access to Contraception Does Not Increase Adolescent Sexual Activity

20. The federal government incorrectly suggests in the IFRs that increased access to contraception results in increased sexual behavior and has increased adolescent pregnancy rates in the "long term." These assertions are unfounded and ignore rigorous research findings.[24]

21. Adolescent pregnancy has declined dramatically over the past several decades: In 2013, the U.S. pregnancy rate among 15–19-year-olds was at its lowest point in at least 80 years and had dropped to about one-third of a recent peak rate in 1990.[25] The adolescent birthrate has continued to fall sharply from 2013–2016, suggesting that the underlying pregnancy rates have

[23] Sonfield A, Hasstedt K and Gold RB, *Moving Forward: Family Planning in the Era of Health Reform*, New York: Guttmacher Institute, 2014, https://www.guttmacher.org/report/moving-forward-family-planning-era-health-reform.

[24] The government relies on one study to argue that "[p]rograms that increase access to contraception are found to decrease teen pregnancies in the short run but increase teen pregnancies in the long run." This study is based on hypothetical models, with findings based on a set of assumptions feeding into a simulation, rather than evidence from actual programs and the resulting contraceptive behaviors. [See Arcidiacono, Khwaja A and Ouyang L, Habit persistence and teen sex: could increased access to contraception have unintended consequences for teen pregnancies? *Journal of Business and Economic Statistics*, 2012, 30(2):312–325.] By contrast, the bulk of the empirical literature demonstrates a clear connection between contraceptive use and lower rates of adolescent pregnancy. [See 21–24.]

[25] Kost K, Maddow-Zimet I and Arpaia A, Pregnancies, *Births and Abortions Among Adolescents and Young Women in the United States, 2013: National and State Trends by Age, Race and Ethnicity*, New York: Guttmacher Institute, 2017, https://www.guttmacher.org/report/us-adolescent-pregnancy-trends-2013.

likely declined even further.[26] Over these decades, adolescents' sexual activity has not increased—in fact, it has declined—while their contraceptive use has increased.

22. National data limited to adolescents attending high school document long-term increases from 1991–2015 in the share of students using contraception, and decreases over the same time period in the share of students who are sexually active.[27] Several studies have validated that contraceptive access reduces adolescent pregnancy without increasing sexual activity: The vast majority (86%) of the decline in adolescent pregnancy between 1995 and 2002 was the result of improvements in contraceptive use; only 14% could be attributed to a decrease in sexual activity.[28] Further, when examining these same two factors, all of the decline in the more recent 2007–2012 period was attributable to better contraceptive use: More adolescents were using contraception, they were using more effective methods, and they were using them more consistently, while adolescent sexual activity did not change.[29]

23. Recent trends in adolescent contraceptive use buttress this point: During 2011–2015, 81% of adolescent girls used contraception the first time they had sex, up from 75% in 2002; the share of adolescent girls who were sexually active stayed stable.[30,31] Similarly, use of emergency contraception among sexually active female adolescents increased from 8% in 2002 to

[26] Martin JA, Hamilton BE and Osterman MJK, Births in the United States, 2016, *NCHS Data Brief*, 2017, No. 287, https://www.cdc.gov/nchs/products/databriefs.htm.
[27] National Center for HIV/AIDS, Viral Hepatitis, TD, and TB Prevention, Centers for Disease Control and Prevention (CDC), *Trends in the Prevalence of Sexual Behaviors and HIV Testing National YRBS: 1991–2015,* Atlanta: CDC, no date, https://www.cdc.gov/healthyyouth/data/yrbs/pdf/trends/2015_us_sexual_trend_yrbs.pdf.
[28] Santelli JS et al., Explaining recent declines in adolescent pregnancy in the United States: the contribution of abstinence and improved contraceptive use, *American Journal of Public Health*, 2007, 97(1): 150–156, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1716232/.
[29] Lindberg L, Santelli J and Desai S, Understanding the decline in adolescent fertility in the United States, 2007–2012, *Journal of Adolescent Health*, 2016, 59(5): 577–583, http://www.jahonline.org/article/S1054-139X(16)30172-0/fulltext.
[30] Martinez G, Copen CE and Abma JC, Teenagers in the United States: Sexual activity, contraceptive use, and childbearing, 2006–2010 National Survey of Family Growth, *Vital Health Statistics*, 2011, Series 23, No. 31, https://www.cdc.gov/nchs/products/series/series23.htm.
[31] Abma JC and Martinez G, Sexual activity and contraceptive use among teenagers in the United States, 2011–2015, *National Health Statistics Reports*, 2017, No. 104, https://www.cdc.gov/nchs/products/nhsr.htm.

22% in 2011–2013; there was no significant change in sexual activity during this time.[32] And in a 2010 review of seven randomized trials of emergency contraception, there was no increase in sexual activity (e.g., reported number of sexual partners or number of episodes of unprotected intercourse) in adolescents given advanced access to emergency contraception.[33]

24. Along the same lines, studies of the availability of contraception in high schools provide evidence that it does not lead to more sexual activity. Rather, while several studies of school-based health care centers that provide contraceptive methods have shown contraceptives' availability increases students' use of contraception,[34,35] other studies have not found any associated increases in sexual activity.[36] And a recent review of studies of school-based condom availability programs found condom use increased the odds of students using condoms, while none increased sexual activity.[37]

Eliminating the Cost of Contraception Leads to Improved Contraceptive Use and Reduces Women's Risk of Unintended Pregnancy

25. Extensive empirical evidence demonstrates what common sense would predict: eliminating costs leads to more effective and continuous use of contraception. This is because cost can be a substantial barrier to contraceptive choice. The contraceptive methods that can be purchased over the counter at a neighborhood drugstore for a comparatively low cost—male

[32] Martinez GM and Abma JC, Sexual activity, contraceptive use, and childbearing of teenagers aged 15–19 in the United States, *NCHS Data Brief*, 2015, No. 209, https://www.cdc.gov/nchs/products/databriefs.htm.
[33] Meyer JL, Gold MA and Haggerty CL, Advance provision of emergency contraception among adolescent and young adult women: a systematic review of literature, *Journal of Pediatric and Adolescent Gynecology,* 2011, 24(1):2–9, http://www.jpagonline.org/article/S1083-3188(10)00203-2/fulltext.
[34] Minguez M et al., Reproductive health impact of a school health center, *Journal of Adolescent Health*, 2015, 56(3): 338–344, https://www.ncbi.nlm.nih.gov/pubmed/25703321.
[35] Knopf FA et al., School-based health centers to advance health equity: a Community Guide systematic review, *American Journal of Preventive Medicine*, 2016, 51(1): 114-126, http://www.ajpmonline.org/article/S0749-3797(16)00035-0/fulltext.
[36] Kirby D, *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*, Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy, 2007, https://thenationalcampaign.org/sites/default/files/resource-primary-download/EA2007_full_0.pdf.
[37] Wang T et al., The effects of school-based condom availability programs (CAPs) on condom acquisition, use and sexual behavior: a systematic review, *AIDS and Behavior*, 2017, https://www.ncbi.nlm.nih.gov/pubmed/28625012.

condoms and spermicide—are far less effective than methods that require a prescription and a visit to a health care provider,[38] which have higher up-front costs.[39]

26. The most effective methods of contraception are long-acting reversible contraceptives ("LARC"), such as implants and IUDs. Even with discounts for volume, the cost of these devices exceeds $500, exclusive of costs relating to the insertion procedure,[40] and the total cost of initiating one of these methods generally exceeds $1,000.[41] To put that cost in perspective, beginning to use one of these devices costs nearly a month's salary for a woman working full time at the federal minimum wage of $7.25 an hour.[42] These costs are dissuasive for many women not covered by the contraceptive coverage guarantee; one pre-ACA study concluded that women who faced high out-of-pocket IUD costs were significantly less likely to obtain an IUD than women with access to the device at low or no out-of-pocket cost. And only 25% of women who requested an IUD had one placed after learning the associated costs.[43] Even oral contraceptives, which are twice as effective as condoms in practice, require a prescription and a cost that is incurred every month. And although some stores offer certain pill formulations at steep discounts, requiring a woman to change to a different formulation because of cost has the potential for adverse health effects.

27. The government acknowledges that without coverage, many methods would cost women $50 per month, or upwards of $600 per year, and in doing so, implies that such costs are a minimal burden.[44] This is not true. About one-third of uninsured people and lower-income people

[38] Trussell J, Contraceptive efficacy, in: Hatcher RA et al., eds., *Contraceptive Technology*, 20th ed., New York: Ardent Media, 2011, pp. 779–863.
[39] Trussell J et al., Cost effectiveness of contraceptives in the United States, *Contraception*, 2009, 79(1):5–14.
[40] Armstrong E et al., *Intrauterine Devices and Implants: A Guide to Reimbursement*, 2015, https://www.nationalfamilyplanning.org/file/documents----reports/LARC_Report_2014_R5_forWeb.pdf.
[41] Eisenberg D et al., Cost as a barrier to long-acting reversible contraceptive (LARC) use in adolescents, *Journal of Adolescent Health*, 2013, 52(4):S59–S63, http://www.jahonline.org/article/S1054-139X(13)00054-2/fulltext.
[42] 29 U.S.C. § 206(a)(1)(C). At 40 hours a week, that amounts to $290 a week, before any taxes or deductions.
[43] Gariepy AM et al., The impact of out-of-pocket expense on IUD utilization among women with private insurance, *Contraception*, 2011, 84(6):e39–e42, https://escholarship.org/uc/item/1dz6d3cx.
[44] The government includes IUDs as one of the methods that costs $50 per month. That is not accurate because an IUD cannot be paid month to month, but instead requires a high up-front cost. Perhaps the government has confused an IUD with another method that has recurring monthly costs, such as the patch or the ring.

would be unable to pay for an unexpected $500 medical bill, and roughly another third would have to borrow money or put it on a credit card and pay it back over time, with interest.[45]

28. Without insurance coverage to defray or eliminate the cost, the large up-front costs of the more-effective contraceptive methods put them out of reach for many women who otherwise would want to use them, and drive women to less expensive and less effective methods. In a study conducted prior to the contraceptive coverage guarantee, almost one-third of women reported that they would change their contraceptive method if cost were not an issue.[46] This figure was particularly high among women relying on male condoms and other less effective methods such as withdrawal. A study conducted after the ACA had similar findings: among women in the study who still lacked health insurance in 2015, 44% agreed that having insurance would help them to afford and use birth control and 44% agreed that it would allow them to choose a better method; 48% also agreed that it would be easier to use contraception consistently if they had coverage.[47] Among insured women who still had a copayment using a prescription method (e.g., those in grandfathered plans), 40% agreed that if the copayment were eliminated, they would be better able to afford and use birth control, 32% agreed this would help them choose a better method, and 30% agreed this would help them to use their methods of contraception more consistently. Other studies have found that uninsured women are less likely to use the most expensive (but most effective) contraceptive methods, such as IUDs, implants, and oral

[45] DiJulio B et al., Data note: Americans' challenges with health care costs, 2017, https://www.kff.org/health-costs/poll-finding/data-note-americans-challenges-with-health-care-costs/?utm_campaign=KFF-2017-March-Polling-Beyond-The-ACA.

[46] Frost JJ and Darroch JE, Factors associated with contraceptive choice and inconsistent method use, United States, 2004, *Perspectives on Sexual and Reproductive Health,* 2008, 40(2):94–104, https://www.guttmacher.org/journals/psrh/2008/factors-associated-contraceptive-choice-and-inconsistent-method-use-united.

[47] Bearak JM and Jones RK, Did contraceptive use patterns change after the Affordable Care Act? A descriptive analysis, *Women's Health Issues*, 2017, 27(3):316–321, http://www.whijournal.com/article/S1049-3867(17)30029-4/fulltext.

contraceptives,[48] and are more likely than insured women to report using no contraceptive method at all.[49,50]

29. Reducing financial barriers is key to increasing access to effective contraception. Notably, before the ACA provision went into effect, 28 states required private insurers that cover prescription drugs to provide coverage of most or all FDA-approved contraceptive drugs and devices.[51] These programs gave women access at lower prices than if contraception were not covered, but (at the time) all states still allowed insurers to require cost-sharing. Experience from these states demonstrates that having insurance coverage matters.[52] Privately insured women living in states that required private insurers to cover prescription contraceptives were 64% more likely to use some contraceptive method during each month a sexual encounter was reported than women living in states with no such requirement, even after accounting for differences including education and income.[53]

30. Although these state policies reduced women's up-front costs, other actions to eliminate out-of-pocket costs entirely—which is what the federal contraceptive coverage guarantee has done for most privately insured women—have even greater potential to increase effective contraceptive use. For example, when Kaiser Permanente Northern California

[48] Culwell KR and Feinglass J, The association of health insurance with use of prescription contraceptives, *Perspectives on Sexual and Reproductive Health,* 2007, 39(4):226–230.
[49] Culwell KR and Feinglass J, The association of health insurance with use of prescription contraceptives, *Perspectives on Sexual and Reproductive Health,* 2007, 39(4):226–230.
[50] Culwell KR and Feinglass J, Changes in prescription contraceptive use, 1995–2002: the effect of insurance coverage, *Obstetrics & Gynecology*, 2007, 110(6):1371–1378, https://www.ncbi.nlm.nih.gov/pubmed/18055734.
[51] Guttmacher Institute, Insurance coverage of contraceptives*, State Policies in Brief (as of July 2012)*, 2012.
[52] The government asserts in the IFRs that "Additional data indicates that, in 28 States where contraceptive coverage mandates have been imposed statewide, those mandates have not necessarily lowered rates of unintended pregnancy (or abortion) overall." The study the government relies on for this assertion was published in a law review rather than in a peer-reviewed scientific journal. [See New MJ, Analyzing the impact of state level contraception mandates on public health outcomes, *Ave Maria Law Review,* 2015, 13(2):345–369.] One basic flaw in this article is that, at the time, none of the state contraceptive coverage laws eliminated out-of-pocket costs entirely, which is the major advance from the federal guarantee and the issue in this case. In addition, over the course of the period the article evaluated, many states enacted contraceptive coverage laws in quick succession. [Sonfield et al. U.S. insurance coverage of contraceptives and impact of contraceptive coverage mandates, 2002, *Perspectives on Sexual and Reproductive Health,* 2004, 36(2):72–79, https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/3607204.pdf.] Contraceptive coverage became the norm in the insurance industry—even in states without mandates—thus minimizing potential differences between states with laws and states without them.
[53] Magnusson BM et al., Contraceptive insurance mandates and consistent contraceptive use among privately insured women, *Medical Care*, 2012, 50(7):562–568.

eliminated patient cost-sharing requirements for IUDs, implants, and injectables in 2002, the use of these devices increased substantially, with IUD use more than doubling.[54] Another example comes from a study of more than 9,000 St. Louis-region women who were offered the reversible contraceptive method of their choice (i.e., any method other than sterilization) at no cost for two to three years, and were "read a brief script informing them of the effectiveness and safety of" IUDs and implants.[55] Three-quarters of those women chose long-acting methods (i.e., IUDs or implants), a level far higher than in the general population. Likewise, a Colorado study found that use of long-acting reversible contraceptive methods quadrupled when offered with no out-of-pocket costs along with other efforts to improve access.[56]

31. Government-funded programs to help low-income people afford family planning services provide further evidence that reducing or eliminating cost barriers to women's contraceptive choices has a dramatic impact on women's ability to choose and use the most effective forms of contraception. Each year, among the women who obtain contraceptive services from publicly funded reproductive health providers, 57% select hormone-based contraceptive methods, 18% use implants or IUDs, and 7% receive a tubal ligation.[57] It is estimated that without publicly supported access to these methods at low or no cost, nearly half (47%) of those women would switch to male condoms or other nonprescription methods, and 28% would use no contraception at all.[58]

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[54] Postlethwaite D et al., A comparison of contraceptive procurement pre- and post-benefit change, *Contraception*, 2007, 76(5): 360–365

[55] Peipert JF et al., *Preventing unintended pregnancies by providing no-cost contraception*, *Contraception*, 2012, 120(6):1291–1297.

[56] Ricketts S, Klinger G and Schwalberg G, Game change in Colorado: widespread use of long-acting reversible contraceptives and rapid decline in births among young, low-income women, *Perspectives on Sexual and Reproductive Health,* 2014, 46(3):125–132.

[57] Frost JJ and Finer LB, Unintended pregnancies prevented by publicly funded family planning services: Summary of results and estimation formula, memo to interested parties, New York: Guttmacher Institute, June 23, 2017, https://www.guttmacher.org/sites/default/files/pdfs/pubs/Guttmacher-Memo-on-Estimation-of-Unintended-Pregnancies-Prevented-June-2017.pdf.

[58] Frost JJ and Finer LB, Unintended pregnancies prevented by publicly funded family planning services: Summary of results and estimation formula, memo to interested parties, New York: Guttmacher Institute, June 23, 2017, https://www.guttmacher.org/sites/default/files/pdfs/pubs/Guttmacher-Memo-on-Estimation-of-Unintended-Pregnancies-Prevented-June-2017.pdf.

The ACA's Contraceptive Coverage Guarantee Has Had a Positive Impact

32. By ensuring coverage for a full range of contraceptive methods, services and counseling at no cost, the ACA's contraceptive coverage mandate has had its intended effect of removing cost barriers to obtaining contraception. Between fall 2012 and spring 2014 (during which time the coverage guarantee went into wide effect), the proportion of privately insured women who paid nothing out of pocket for the pill increased from 15% to 67%, with similar changes for injectable contraceptives, the vaginal ring and the IUD.[59] Similarly, another study found that since implementation of the ACA, the share of women of reproductive age (regardless of whether they were using contraception) who had out-of-pocket spending on oral contraceptives decreased from 21% in 2012 to just 4% in 2014.[60] These trends have translated into considerable savings for U.S. women: one study estimated that pill and IUD users saved an average of about $250 in copayments in 2013 alone because of the guarantee.[61]

33. Prior to the ACA, contraceptives accounted for between 30–44% of out-of-pocket health care spending for women.[62] Individual women themselves say that the ACA's contraceptive coverage guarantee is working for them. In a 2015 nationally representative survey of women aged 18–39, two-thirds of those who had health insurance and were using a hormonal contraceptive method reported having no copays; among those women, 80% agreed that paying nothing out of pocket helped them to afford and use their birth control, 71% agreed this helped them use their birth control consistently, and 60% agreed that having no copayment helped them choose a better method.[63]

[59] Sonfield A et al. Impact of the federal contraceptive coverage guarantee on out-of-pocket payments for contraceptives: 2014 update, *Contraceptive*, 2015, 91(1):44–48.
[60] Sobel L, Salganicoff A and Rosenzweig C, *The Future of Contraceptive Coverage*, Kaiser Family Foundation (KFF) Issue Brief, Menlo Park, CA: KFF, 2017, https://www.kff.org/womens-health-policy/issue-brief/the-future-of-contraceptive-coverage/.
[61] Becker NV and Polsky D, Women saw large decrease in out-of-pocket spending for contraceptives after ACA mandate removed cost sharing, *Health Affairs*, 2015, 34(7):1204–1211.
[62] Becker NV and Polsky D, Women saw large decrease in out-of-pocket spending for contraceptives after ACA mandate removed cost sharing, *Health Affairs*, 2015, 34(7):1204–1211.
[63] Bearak JM and Jones RK, Did contraceptive use patterns change after the Affordable Care Act? A descriptive analysis, *Women's Health Issues*, 2017, 27(3):316–321, http://www.whijournal.com/article/S1049-3867(17)30029-4/fulltext.

34. Demonstrating the population-level impact of the ACA's coverage provision is complicated, because the provision affects only a subset of U.S. women, and because there are so many additional variables that may have affected women's contraceptive use in a number of ways. The evidence on whether the ACA's provision has affected contraceptive use at the population level is not definitive, but some studies suggest the guarantee has had an impact on contraceptive use, among those benefiting from the provision.

35. A study using claims data from 30,000 privately insured women in the Midwest found that the ACA's reduction in cost sharing was tied to a significant increase in the use of prescription methods from 2008 through 2014 (before and after the ACA provision went into effect), particularly long-acting methods.[64] Another study of health insurance claims from 635,000 privately insured women nationwide showed that rates of discontinuation and inconsistent use of contraception declined from 2010 to 2013 (again, before and after the ACA provision went into effect) among women using generic oral contraceptive pills after the contraceptive guarantee's implementation (among women using brand-name oral contraceptives, only the discontinuation rate declined).[65]

36. Two other studies, looking at the broader U.S. population, found no change in overall use of contraception or an overall switch from less-effective to more-effective methods among women at risk of unintended pregnancy before and after the guarantee's implementation.[66,67] However, both studies identified some positive trends among key groups. One of them found that between 2008 and 2014, among women aged 20–24 (the age group at highest risk for unintended pregnancy), LARC use more than doubled, from 7% to 19%, without

[64] Carlin CS, Fertig AR and Down BE, Affordable Care Act's mandate eliminating contraceptive cost sharing influenced choices of women with employer coverage, *Health Affairs,* 2016, 35(9):1608–1615.
[65] Pace LE, Dusetzina SB and Keating NL, Early impact of the Affordable Care Act on oral contraceptive cost sharing, discontinuation, and nonadherence, *Health Affairs,* 2016, 35(9):1616–1624.
[66] Bearak JM and Jones RK, Did contraceptive use patterns change after the Affordable Care Act? A descriptive analysis, *Women's Health Issues*, 2017, 27(3):316–321, http://www.whijournal.com/article/S1049-3867(17)30029-4/fulltext.
[67] Kavanaugh ML and Jerman J, Contraceptive method use in the United States: trends and characteristics between 2008, 2012 and 2014, *Contraception*, 2017, https://www.guttmacher.org/article/2017/10/contraceptive-method-use-united-states-trends-and-characteristics-between-2008-2012.

a proportional decline in sterilization.[68] The other study showed that between 2012 and 2015, use of prescription contraceptive methods, and birth control pills in particular, increased among sexually inactive women, suggesting that more women were able to start a method before becoming sexually active or use a method such as the pill for noncontraceptive reasons after implementation of the contraceptive coverage guarantee.[69]

37. There is also considerable empirical data from controlled experiments to confirm that the concept of removing cost as a barrier to women's contraceptive use is a major factor in reducing their risk for unintended pregnancy, and the abortions and unplanned births that would otherwise follow. For example, a study of more than 9,000 St. Louis-region women who were offered the reversible contraceptive method of their choice at no cost found that the number of abortions performed at St. Louis Reproductive Health Services declined by 21%.[70] Study participants' abortion rate was significantly lower than the rate in the surrounding St. Louis region, and less than half the national average.[71] Similarly, when access to both contraception and abortion increased in Iowa, the abortion rates actually declined.[72] Starting in 2006, the state expanded access to low- or no-cost family planning services through a Medicaid expansion and a privately funded initiative serving low-income women. Despite a simultaneous increase in access to abortion—the number of clinics offering abortions in the state actually doubled during the study period—the abortion rate dropped by over 20%.

Expanding Exemptions Will Harm Women

38. The IFRs will make it more difficult, once again, for those receiving insurance coverage through companies or schools that use the exemption (i.e., employees, students and

[68] Kavanaugh ML and Jerman J, Contraceptive method use in the United States: trends and characteristics between 2008, 2012 and 2014, *Contraception*, 2017, https://www.guttmacher.org/article/2017/10/contraceptive-method-use-united-states-trends-and-characteristics-between-2008-2012.

[69] Bearak JM and Jones RK, Did contraceptive use patterns change after the Affordable Care Act? A descriptive analysis, *Women's Health Issues*, 2017, 27(3):316–321, http://www.whijournal.com/article/S1049-3867(17)30029-4/fulltext.

[70] Peipert JF et al., *Preventing unintended pregnancies by providing no-cost contraception*, *Contraception*, 2012, 120(6):1291–1297.

[71] Peipert JF et al., *Preventing unintended pregnancies by providing no-cost contraception*, *Contraception*, 2012, 120(6):1291–1297.

[72] Biggs MA, Did increasing use of highly effective contraception contribute to declining abortions in Iowa? *Contraception,* 2015, 91(2):167–173.

dependents) to access the methods of contraception that are most acceptable and effective for them. That, in turn, will increase those women's risk of unintended pregnancy and interfere with their ability to plan and space wanted pregnancies. These barriers could therefore have considerable negative health, social and economic impacts for those women and their families.

39. Allowing employers or schools to exclude all contraceptive methods, services and counseling from insurance plans—or to cover some contraceptive methods, services and information but not others—will prevent women from selecting and obtaining the methods of contraception that will work best for them. For example, Hobby Lobby objected to providing four specific contraceptive methods, including copper and hormonal IUDs, which are among the most effective forms of pregnancy prevention and also have among the highest up-front costs.

40. Allowing employers to restrict access to the full range of contraceptive methods and to approve coverage only for those they deem acceptable places inappropriate constraints on women who depend on insurance to obtain the methods best suited to their needs. Moreover, in the absence of coverage, the financial cost of obtaining a method, and the fact that some methods have higher costs than others, would incentivize women to select methods that are inexpensive, rather than methods that are best suited to their needs and that they are therefore most likely to use consistently and effectively (see 10–19, above).

41. Excluding coverage for some or all contraceptive methods, services and counseling could deny women the ability to obtain contraceptive counseling and services from their desired provider at the same time they receive other primary and preventive care.[73,74] A woman going to her gynecologist for an annual examination, for example, may have to go to a different provider to be prescribed (or even discuss) contraception. This disjointed approach increases the time, effort and expense involved in getting needed contraception and interferes with her ability to obtain care from the provider of her choice.

[73] Leeman L, Medical barriers to effective contraception, *Obstetrics and Gynecology Clinics of North America,* 2007, 34(1):19–29.
[74] World Health Organization, Selected Practice Recommendations for Contraceptive Use, Third Ed., 2016, WHO: Geneva, Switzerland, http://apps.who.int/iris/bitstream/10665/252267/1/9789241565400-eng.pdf.

42. Isolating contraceptive coverage in this way also would interfere with the ability of health care providers to treat women holistically. A woman's choice of contraception can be affected by her other medical conditions (e.g., diabetes, HIV, depression/mental health), and certain medications can significantly reduce the effectiveness of some methods of contraception, so a woman's chosen provider should be able to manage all health conditions and needs at the same time.[75,76]

43. To the extent that expanding the exemptions will burden women's contraceptive use in these ways, it will be harmful to women's health. Contraception allows women to avoid unintended pregnancies and to time and space wanted pregnancies, all of which have been demonstrated to improve women's health and that of their families. Specifically, pregnancies that occur too early or too late in a woman's life, or that are spaced too closely, negatively affect maternal health and increase the risk of harmful birth outcomes, including preterm birth, low birth weight, stillbirth, and early neonatal death.[77] Closely spaced pregnancies are associated with increased risk of harmful birth outcomes.[78,79,80] Contraceptive use can also prevent preexisting health conditions from worsening and new health problems from occurring, because pregnancy can exacerbate existing health conditions such as diabetes, hypertension and heart disease.[81] Unintended pregnancy also affects women's mental health; notably, it is a risk factor for

[75] Centers for Disease Control and Prevention, *US Medical Eligibility Criteria for Contraceptive Use, 2016,* https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html.
[76] Centers for Disease Control and Prevention, U.S. medical eligibility criteria for contraceptive use, 2010, *Morbidity and Mortality Weekly Report,* May 28, 2010, Vol. 59, https://www.cdc.gov/mmwr/pdf/rr/rr59e0528.pdf.
[77] Kavanaugh ML and Anderson RM, *Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers,* New York: Guttmacher Institute, 2013, http://www.guttmacher.org/report/contraception-and-beyond-health-benefits-services-provided-family-planning-centers.
[78] Wendt A et al., Impact of increasing inter-pregnancy interval on maternal and infant health, Paediatric and Perinatal Epidemiology, 2012, 26(Suppl. 1):239–258.
[79] Conde-Agudelo A, Rosas-Bermúdez A and Kafury-Goeta AC, Birth spacing and risk of adverse perinatal outcomes: a meta-analysis, Journal of the American Medical Association, 2006, 295(15):1809–1823.
[80] Gipson JD, Koenig MA and Hindin MJ, The effects of unintended pregnancy on infant, child, and parental health: a review of the literature, *Studies in Family Planning,* 2008, 39(1):18–38.
[81] Lawrence HC, Testimony of American Congress of Obstetricians and Gynecologists, submitted to the Committee on Preventive Services for Women, Institute of Medicine, 2011, http://www.nationalacademies.org/hmd/~/media/8BA65BAF76894E9EB8C768C01C84380E.ashx.

depression in adults.[82,83] For these reasons, the Centers for Disease Control and Prevention included the development of and improved access to methods of family planning among the 10 great public health achievements of the 20th century because of its numerous benefits to the health of women and children.[84]

44. The government implies in the IFRs that contraception may have negative health consequences that outweigh its benefits. Again, this is demonstrably false, and the government itself provides the oversight to ensure that it is false. Notably, the U.S. Food and Drug Administration's approval processes require that drugs and devices, including contraceptives, be proven safe through rigorous controlled trials. In addition, the Centers for Disease Control and Prevention publish extensive recommendations to help clinicians and patients identify potential contraindications and decide which specific contraceptive methods are most appropriate for each patient's specific needs and health circumstances.[85,86] Medical experts, such as the American College of Obstetricians and Gynecologists, concur that contraception is safe and has clear health benefits that outweigh any potential side effects.[87]

45. Expanding the exemptions to the contraceptive coverage requirement will also have negative social and economic consequences for women, families and society. By enabling them to reliably time and space wanted pregnancies, women's ability to obtain and effectively use contraception promotes their continued educational and professional advancement, contributing to the enhanced economic stability of women and their families.[88] Economic analyses have found

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[82] Herd P et al., The implications of unintended pregnancies for mental health in later life, *American Journal of Public Health,* 2016, 106(3):421–429.
[83] U.S. Preventive Services Task Force, Screening for depression in adults: recommendation statement, *American Family Physician,* 2016, 94(4):340A–340D, http://www.aafp.org/afp/2016/0815/od1.html.
[84] Centers for Disease Control and Prevention, Achievements in public health, 1900–1999: family planning, *Morbidity and Mortality Weekly Report,* 1999, 48(47): 1073–1080.
[85] Centers for Disease Control and Prevention, *US Medical Eligibility Criteria for Contraceptive Use, 2016,* https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html.
[86] Centers for Disease Control and Prevention, U.S. medical eligibility criteria for contraceptive use, 2010, *Morbidity and Mortality Weekly Report,* May 28, 2010, Vol. 59, https://www.cdc.gov/mmwr/pdf/rr/rr59e0528.pdf.
[87] Brief of *Amici Curiae,* American College of Obstetricians and Gynecologists, Physicians for Reproductive Health, American Academy of Family Physicians, American Nurses Association, et al., *Zubik v. Burwell,* 2016, http://www.scotusblog.com/wp-content/uploads/2016/02/Docfoc.com-Amicus-Brief-Zubik-v.-Burwell.pdf.
[88] Sonfield A et al., *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children,* New York: Guttmacher Institute, 2013, https://www.guttmacher.org/report/social-and-economic-benefits-womens-ability-determine-whether-and-when-have-children.

positive associations between women's ability to obtain and use oral contraceptives and their education, labor force participation, average earnings and a narrowing of the gender-based wage gap.[89] Moreover, the primary reasons women give for why they use and value contraception are social and economic: In a 2011 study, a majority of women reported that access to contraception had enabled them to take better care of themselves or their families (63%), support themselves financially (56%), stay in school or complete their education (51%), or get or keep a job or pursue a career (50%).[90]

46. The government argues that expanding the exemption will not impose any real harm, suggesting that the women most at risk for unintended pregnancy are not likely to be covered by employer-based group health plans or by student insurance sponsored by a college or university. This argument is misleading. Low-income women, women of color and women aged 18–24 are at disproportionately high risk for unintended pregnancy,[91] and millions of these women rely on private insurance coverage—particularly following implementation of the ACA. In fact, from 2013 to 2015, the proportion of women overall and of women living below the poverty level who were uninsured each dropped by roughly one-third nationwide, declines driven by substantial increases in both Medicaid and private insurance coverage.[92] In addition, the ACA specifically expanded coverage for people aged 26 and younger, allowing them to remain covered as dependents on their parents' plans, regardless of whether the young woman is working herself or attending college or university.

[89] Sonfield A et al., *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children,* New York: Guttmacher Institute, 2013, https://www.guttmacher.org/report/social-and-economic-benefits-womens-ability-determine-whether-and-when-have-children.

[90] Frost JJ and Lindberg LD, Reasons for using contraception: perspectives of U.S. women seeking care at specialized family planning clinics, 2012, *Contraception,* http://www.guttmacher.org/pubs/journals/j.contraception.2012.08.012.pdf.

[91] Finer LB and Zolna MR, Declines in unintended pregnancy in the United States, 2008–2011, *New England Journal of Medicine*, 2016, 374(9):843–852.

[92] Guttmacher Institute, Uninsured rate among women of reproductive age has fallen more than one-third under the Affordable Care Act, *News in Context,* Nov. 17, 2016, https://www.guttmacher.org/article/2016/11/uninsured-rate-among-women-reproductive-age-has-fallen-more-one-third-under.

Medicaid, Title X and State Coverage Requirements Cannot Substitute for the Federal Contraceptive Coverage Guarantee

47. The government claims that "[i]ndividuals who are unable to obtain contraception coverage through their employer-sponsored health plans because of the exemptions created in these interim final rules … have other avenues for obtaining contraception…"[93] But the programs and laws the government highlights—the Title X national family planning program, Medicaid, and state contraceptive coverage requirements—simply cannot replicate or replace the gains in access made by the contraceptive coverage guarantee.

48. Many women who have the benefit of the ACA's contraceptive coverage mandate are not eligible for free or subsidized care under Title X. Title X provides no-cost family planning services to people living at or below 100% of the federal poverty level ($12,060 for a single person in 2017),[94] and provides services on a sliding fee scale between 100% and 250% of poverty; women above 250% of poverty must pay the full cost of care. By contrast, the federal contraceptive coverage guarantee eliminates out-of-pocket costs for contraception regardless of income.

49. Funding for Title X has not increased sufficiently for the program to even keep up with the increasing number of women in need of publicly funded care;[95] therefore, Title X cannot sustain additional beneficiaries as a result of the IFRs. From 2010 to 2014, even as the number of women in need of publicly funded contraceptive care grew by 5%, representing an additional 1 million women in need,[96] Congress cut funding for Title X by 10%.[97] With its current resources,

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[93] Department of the Treasury, Department of Labor and Department of Health and Human Services, Religious exemptions and accommodations for coverage of certain preventive services under the Affordable Care Act, *Federal Register*, 82(197):47838–47862, https://www.gpo.gov/fdsys/pkg/FR-2017-10-13/pdf/2017-21852.pdf.

[94] Office of the Assistant Secretary for Planning and Evaluation, U.S. federal poverty guidelines used to determine financial eligibility for certain federal programs, 2017, https://aspe.hhs.gov/poverty-guidelines.

[95] Women in need of publicly funded contraceptive services are defined as those 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. See Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update,* New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

[96] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update,* New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

[97] Department of Health and Human Services, Office of Population Affairs, Funding history, 2017, https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/funding-history/index.html.

Title X is only able to serve one-fifth of the nationwide need for publicly funded contraceptive care.[98]

50. Similarly, many women who would lose private insurance coverage of contraception under the federal government's expanded exemption would not be eligible for Medicaid. Eligibility for Medicaid varies widely from state to state, particularly in the 19 states that have not expanded Medicaid eligibility under the ACA. In 18 of those 19 states, nondisabled, nonelderly childless adults do not qualify for Medicaid at any income level, and eligibility for parents is as low as 18% of the federal poverty level in Texas.[99] Nine of these 19 states have expanded eligibility specifically for family planning services to people otherwise ineligible for full-benefit Medicaid; those income eligibility levels also vary considerably.[100,101] Again, the federal contraceptive coverage guarantee applies regardless of income. Notably, the U.S. Supreme Court has ruled that states cannot be compelled by the federal government to expand Medicaid eligibility, so the federal government cannot rely on Medicaid to fill in gaps in coverage that would result from expanding the exemption.

51. The federal government's assertion that Title X and Medicaid can replace or replicate the ACA's contraception coverage guarantee is additionally problematic given that the government itself is at the same time proposing to cut funding for Title X and Medicaid or otherwise undermine the programs. For example, the government's FY 2018 budget proposal sought to exclude Planned Parenthood Federation of America and its affiliates from Title X, Medicaid and other federal programs;[102] Planned Parenthood health centers serve 32% of all

[98] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update,* New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

[99] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2017, State Health Facts, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.

[100] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of October 2017),* 2017, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.

[101] Kaiser Family Foundation, Status of state action on the Medicaid expansion decision, 2017, State Health Facts, https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

[102] Hasstedt K, Beyond the rhetoric: the real-world impact of attacks on Planned Parenthood and Title X, *Guttmacher Policy Review,* 2017, 20:86–91, https://www.guttmacher.org/gpr/2017/08/beyond-rhetoric-real-world-impact-attacks-planned-parenthood-and-title-x.

female contraceptive clients who obtain care from a safety-net family planning center, and 41% of all Title X clients.[103] Moreover, the FY 2018 budget called for massive cuts to Medicaid (somewhere between $610 billion and $1.4 trillion over a 10-year period[104]), and the Department of Health and Human Services has encouraged states to revamp their Medicaid programs in ways that would restrict program eligibility (e.g., by imposing work requirements) and thereby interfere with coverage and care.[105] In addition, a White House memo that was leaked to the press in October 2017 included a request to cut funding for Title X at least by half, which would fundamentally undermine the program's mandate to deliver affordable, high-quality contraceptive care.[106] The administration has strongly backed similar congressional proposals for cutting and limiting access to Title X and Medicaid.

52. Policymakers in many states have also restricted publicly funded family planning programs and providers, further undermining the ability of these programs to serve those affected by the expanded exemption.[107]

53. Neither can state-specific contraceptive coverage laws replicate or replace the increase in access to contraception provided by the ACA's contraceptive coverage guarantee. Twenty-two states and the District of Columbia, home to 43% of women of reproductive age in 2016,[108] have no such laws at all.[109] Of the 28 states that do have contraceptive coverage requirements, only four currently bar copayments and deductibles for contraception (and another four states have new requirements not yet in effect). Additionally, the federal requirement limits

[103] Frost JJ et al., *Publicly Funded Contraceptive Services at U.S. Clinics, 2015*, New York: Guttmacher Institute, 2017, https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015.
[104] Luhby T, Not even the White House knows how much it's cutting Medicaid, *CNN,* May 24, 2017, http://money.cnn.com/2017/05/24/news/economy/medicaid-budget-trump/index.html.
[105] Sonfield A, Efforts to transform the nature of Medicaid could undermine access to reproductive health care, *Guttmacher Policy Review,* 2017, 20:97–102, https://www.guttmacher.org/gpr/2017/10/efforts-transform-nature-medicaid-could-undermine-access-reproductive-health-care.
[106] Beutler B, Leaked memo reveals White House wish list, *Crooked,* Oct. 19, 2017. https://crooked.com/article/leaked-memo-reveals-white-house-wish-list/.
[107] Gold RB and Hasstedt K, Publicly funded family planning under unprecedented attack, *American Journal of Public Health,* 2017, 107(12):1895–1897, http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2017.304124.
[108] Department of Health and Human Services, National Center for Health Statistics, Bridged-Race Population Estimates, United States July 1st resident population by state, county, age, sex, bridged-race, and Hispanic origin, accessed on Nov. 3, 2017, http://wonder.cdc.gov/bridged-race-v2016.html.
[109] Guttmacher Institute, Insurance coverage of contraceptives, *State Laws and Policies (as of October 2017),* 2017, http://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives.

the use of formularies and other administrative restrictions on women's use of contraceptive services and supplies, by making it clear that health plans can only influence a patient's choice within a specific contraceptive method category (e.g., to favor one hormonal IUD over another) and not across methods (e.g., to favor the pill over the ring).[110] Few of the state laws include similar protections. Similarly, most of the 28 state requirements do not specifically require coverage of all 18 distinct methods that the federal requirement encompasses. For example, only three states currently require coverage of female sterilization, and few state laws make explicit distinctions between methods that some insurance plans have attempted to treat as interchangeable (such as hormonal versus copper IUDs, or the contraceptive patch versus the contraceptive ring).[111] Finally, state laws cannot regulate self-insured employers at all, and those employers account for 60% of all workers with employer-sponsored health coverage.[112]

State-Specific Impacts

54. The interim final rules will have public health and fiscal impacts in states across the country. If unable to access contraception coverage through their employer or university, some lower-income women who meet the strict income requirements of public programs will rely on publicly funded services to access this beneficial service. Many women who lose or lack contraceptive coverage because their employer or university objects, however, will not meet the strict income and eligibility requirements of public programs, and if as a result they are not using their preferred or the most effective methods for them, or if cost forces them to forgo contraceptive use periodically or altogether, they will be at increased risk of unintended pregnancy. The costs of the resulting unintended pregnancies often then fall to the states because the federal government cannot or will not withstand these costs.

[110] Department 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.
[111] Guttmacher Institute, Insurance coverage of contraceptives, *State Laws and Policies (as of October 2017),* 2017, http://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives.
[112] Claxton G et al., *Employer Health Benefits: 2017 Annual Survey,* Menlo Park, CA: Kaiser Family Foundation; and Chicago: Health Research & Educational Trust, 2017, https://www.kff.org/report-section/ehbs-2017-section-10-plan-funding/.

California

55. In California, some women impacted by the IFRs will not qualify for Medicaid, the state's Medicaid family planning expansion (Family PACT) or Title X because they will not meet the income eligibility requirements for coverage or subsidized care under these programs.

56. For example, in California, childless adults and parents are only eligible for full-benefit Medicaid if they have incomes at or below 138% of the federal poverty level,[113] and individuals are eligible for coverage of family planning services specifically under Family PACT up to 200% of poverty.[114] This means that affected women who lose coverage as a result of the rules may not be eligible.

57. As a result, some women will be at increased risk of unintended pregnancy, either because they are not able to afford the methods that work best for them, or because cost will force them to forgo contraception use entirely.

58. Other women will be eligible for and rely on publicly funded family planning services through programs such as Medicaid, Family PACT and Title X. Those women could be denied the ability to obtain contraceptive counseling and services from their desired provider at the same time they receive other primary and preventive care, increasing the time, effort and expense involved in getting needed contraception. In addition, isolating contraceptive coverage in this way will interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

59. The increase in the number of women relying on publicly funded services will add additional strain to the state's family planning programs and providers, making it more difficult

[113] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2017, State Health Facts, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.

[114] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of October 2017),* 2017, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.

for them to meet the existing need for publicly funded care. In 2014, 2.6 million women were in need of publicly funded family planning in California, and the state's family planning network was only able to meet 50% of this need.[115]

60. Another indicator of the existing unmet need for contraception in California is that substantial numbers of state residents experience unintended pregnancy each year. In 2010, 393,000 unintended pregnancies occurred among California residents, a rate of 50 per 1,000 women aged 15–44.[116]

61. Of those unintended pregnancies that ended in birth, 64% were paid for by Medicaid and other public insurance programs. Unintended pregnancies cost the state approximately $689 million and the federal government approximately $1.06 billion in 2010.[117] The IFRs are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

62. In conclusion, adding to the number of women at risk of unintended pregnancy by expanding the exemption is not in the public health or economic interest of California or its residents.

Delaware

63. In Delaware, some women impacted by the IFRs will not qualify for Medicaid or Title X because they will not meet the income eligibility requirements for coverage or subsidized care under these programs.

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[115] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update,* New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

[116] Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002,* New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002.

[117] Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy.

64. For example, in Delaware, childless adults and parents are only eligible for full-benefit Medicaid if they have incomes at or below 138% of the federal poverty level.[118] (Delaware has not expanded Medicaid eligibility specifically for family planning services.) This means that affected women who lose coverage as a result of the rules may not be eligible.

65. As a result, some women will be at increased risk of unintended pregnancy, either because they are not able to afford the methods that work best for them, or because cost will force them to forgo contraception use entirely.

66. Other women will be eligible for and rely on publicly funded family planning services through programs such as Medicaid and Title X. Those women could be denied the ability to obtain contraceptive counseling and services from their desired provider at the same time they receive other primary and preventive care, increasing the time, effort and expense involved in getting needed contraception. In addition, isolating contraceptive coverage in this way will interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

67. The increase in the number of women relying on publicly funded services will add additional strain to the state's family planning programs and providers, making it more difficult for them to meet the existing need for publicly funded care. In 2014, 50,000 women were in need of publicly funded family planning in Delaware, and the state's family planning network was only able to meet 30% of this need.[119]

68. Another indicator of the existing unmet need for contraception in Delaware is that substantial numbers of state residents experience unintended pregnancy each year. In 2010,

[118] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2017, State Health Facts, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.

[119] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update,* New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

11,000 unintended pregnancies occurred among Delaware residents, a rate of 62 per 1,000 women aged 15–44.[120]

69. Of those unintended pregnancies that ended in birth, 71% were paid for by Medicaid and other public insurance programs. Unintended pregnancies cost the state approximately $36 million and the federal government approximately $58 million in 2010.[121] The IFRs are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

70. In conclusion, adding to the number of women at risk of unintended pregnancy by expanding the exemption is not in the public health or economic interest of Delaware or its residents.

Maryland

71. In Maryland, some women impacted by the IFRs will not qualify for Medicaid or Title X because they will not meet the income eligibility requirements for coverage or subsidized care under these programs.

72. For example, in Maryland, childless adults and parents are only eligible for full-benefit Medicaid if they have incomes at or below 138% of the federal poverty level,[122] and individuals are eligible for coverage of family planning services specifically up to 200% of

[120] Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002,* New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002.

[121] Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy.

[122] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2017, State Health Facts, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.

poverty.[123] This means that affected women who lose coverage as a result of the rules may not be eligible.

73. As a result, some women will be at increased risk of unintended pregnancy, either because they are not able to afford the methods that work best for them, or because cost will force them to forgo contraception use entirely.

74. Other women will be eligible for and rely on publicly funded family planning services through programs such as Medicaid and Title X. Those women could be denied the ability to obtain contraceptive counseling and services from their desired provider at the same time they receive other primary and preventive care, increasing the time, effort and expense involved in getting needed contraception. In addition, isolating contraceptive coverage in this way will interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

75. The increase in the number of women relying on publicly funded services will add additional strain to the state's family planning programs and providers, making it more difficult for them to meet the existing need for publicly funded care. In 2014, 298,000 women were in need of publicly funded family planning in Maryland, and the state's family planning network was only able to meet 25% of this need.[124]

76. Another indicator of the existing unmet need for contraception in Maryland is that substantial numbers of state residents experience unintended pregnancy each year. In 2010,

[123] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of October 2017),* 2017, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.
[124] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update,* New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

71,000 unintended pregnancies occurred among Maryland residents, a rate of 60 per 1,000 women aged 15–44.[125]

77. Of those unintended pregnancies that ended in birth, 58% were paid for by Medicaid and other public insurance programs. Unintended pregnancies cost the state approximately $181 million and the federal government approximately $285 million in 2010.[126] The IFRs are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

78. In conclusion, adding to the number of women at risk of unintended pregnancy by expanding the exemption is not in the public health or economic interest of Maryland or its residents.

New York

79. In New York, some women impacted by the IFRs will not qualify for Medicaid or Title X because they will not meet the income eligibility requirements for coverage or subsidized care under these programs.

80. For example, in New York, childless adults and parents are only eligible for full-benefit Medicaid if they have incomes at or below 138% of the federal poverty level,[127] and individuals are eligible for coverage of family planning services specifically up to 223% of

[125] Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002,* New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002.

[126] Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy.

[127] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2017, State Health Facts, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.

poverty.[128] This means that affected women who lose coverage as a result of the rules may not be eligible.

81. As a result, some women will be at increased risk of unintended pregnancy, either because they are not able to afford the methods that work best for them, or because cost will force them to forgo contraception use entirely.

82. Other women will be eligible for and rely on publicly funded family planning services through programs such as Medicaid and Title X. Those women could be denied the ability to obtain contraceptive counseling and services from their desired provider at the same time they receive other primary and preventive care, increasing the time, effort and expense involved in getting needed contraception. In addition, isolating contraceptive coverage in this way will interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

83. The increase in the number of women relying on publicly funded services will add additional strain to the state's family planning programs and providers, making it more difficult for them to meet the existing need for publicly funded care. In 2014, 1.2 million women were in need of publicly funded family planning in New York, and the state's family planning network was only able to meet 32% of this need.[129]

84. Another indicator of the existing unmet need for contraception in New York is that substantial numbers of state residents experience unintended pregnancy each year. In 2010,

[128] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of October 2017),* 2017, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.
[129] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update,* New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

246,000 unintended pregnancies occurred among New York residents, a rate of 61 per 1,000 women aged 15–44.[130]

85. Of those unintended pregnancies that ended in birth, 70% were paid for by Medicaid and other public insurance programs. Unintended pregnancies cost the state approximately $601 million and the federal government approximately $938 million in 2010.[131] The IFRs are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

86. In conclusion, adding to the number of women at risk of unintended pregnancy by expanding the exemption is not in the public health or economic interest of New York or its residents.

Virginia

87. In Virginia, some women impacted by the IFRs will not qualify for Medicaid or Title X because they may not meet the income eligibility requirements for coverage or subsidized care under these programs. Virginia women may be particularly likely to be impacted by the IFRs because the state does not have its own policy requiring some level of contraceptive coverage among private insurance plans.

88. For example, in Virginia, parents are only eligible for full-benefit Medicaid if they have incomes at or below 38% of the federal poverty level and childless adults are entirely ineligible for full-benefit Medicaid;[132] individuals are only eligible for coverage of family

[130] Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002,* New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002.

[131] Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy.

[132] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2017, State Health Facts, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.

planning services specifically up to 205% of poverty.[133] This means that affected women who lose coverage as a result of the rules may not be eligible.

89. As a result, some women will be at increased risk of unintended pregnancy, either because they are not able to afford the methods that work best for them, or because cost will force them to forgo contraception use entirely.

90. Other women will be eligible for and rely on publicly funded family planning services through programs such as Medicaid and Title X. Those women could be denied the ability to obtain contraceptive counseling and services from their desired provider at the same time they receive other primary and preventive care, increasing the time, effort and expense involved in getting needed contraception. In addition, isolating contraceptive coverage in this way will interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

91. The increase in the number of women relying on publicly funded services will add additional strain to the state's family planning programs and providers, making it more difficult for them to meet the existing need for publicly funded care. In 2014, 448,000 women were in need of publicly funded family planning in Virginia, and the state's family planning network was only able to meet 17% of this need.[134]

92. Another indicator of the existing unmet need for contraception in Virginia is that substantial numbers of state residents experience unintended pregnancy each year. In 2010,

[133] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of October 2017),* 2017, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.
[134] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update,* New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

84,000 unintended pregnancies occurred among Virginia residents, a rate of 51 per 1,000 women aged 15–44.[135]

93. Of those unintended pregnancies that ended in birth, 45% were paid for by Medicaid and other public insurance programs. Unintended pregnancies cost the state approximately $195 million and the federal government approximately $312 million in 2010.[136] The IFRs are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

94. In conclusion, adding to the number of women at risk of unintended pregnancy by expanding the exemption is not in the public health or economic interest of Virginia or its residents.

***

Ample evidence demonstrates that the IFRs will interfere with women's ability to identify and consistently use the contraceptive methods that will work best for them, thus putting them at heightened risk of unintended pregnancy and the health, social and economic harms that will result.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on the 9th day of November, 2017, in New York, New York.

Lawrence B. Finer
Vice President for Domestic Research
The Guttmacher Institute

[135] Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002,* New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002.

[136] Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy.

Exhibit A

Lawrence B. Finer

Guttmacher Institute, 125 Maiden Lane, New York, NY 10038
(646) 438-8770 • lfiner@guttmacher.org

November 2017

Education

12/1999 — Ph.D. in population dynamics, The Johns Hopkins University School of Hygiene and Public Health, Baltimore. Dissertation title: "The consistency and the determinants of reproductive health policy in the American states." Advisor: Nan Astone.

6/1991 — A.B. in psychology *cum laude*, Harvard University, Cambridge, Mass.

Employment

8/2016–present — *Vice President for Domestic Research*, Guttmacher Institute, New York

Provide broad oversight of the Institute's domestic research portfolio as well as the division's personnel and policies. Direct the NIH-funded Guttmacher Center for Population Research Innovation and Dissemination. Management and research duties as described below.

1/2006–7/2016 — *Director of Domestic Research*, Guttmacher Institute

Serve on the Institute's Management Team. Generate project ideas and develop proposals to government and private donors. Directed the Ellertson Social Science Postdoctoral Fellowship at Guttmacher. Management and research duties as described below.

10/2003–12/2005 — *Associate Director for Domestic Research*, Guttmacher Institute

Oversee Guttmacher's domestic research portfolio. Participate in project idea generation and proposal development/grant writing. Serve on the Institute's retirement investment committee. Perform substantive reviews, oversee budgets and time, and conduct original research as described below.

1/2001–9/2003 — *Assistant Director of Research*, Guttmacher Institute

Perform substantive reviews to ensure quality of work of senior and junior staff. Plan and monitor division budgets and staff time allocation. Serve on the Institute's retirement investment committee. Conduct original research as described below.

12/1998–12/2000 — *Senior Research Associate*, Guttmacher Institute

Conduct original policy-relevant research in the areas of contraceptive

use, unintended pregnancy, and abortion, using both quantitative and qualitative methods. Manage research projects, including surveys of providers and patients; analyze data collected and conduct secondary analyses of large datasets; and write up and publish results. Design and implement systems to improve infrastructure and data storage in the Research division and at the Institute. Represent Guttmacher at professional meetings and to the media.

12/2005–present *Senior Lecturer*, Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University, New York

Lecture on topics related to sexual and reproductive health to students at the Mailman School of Public Health. Present research at department seminars.

9/1997–12/1998 *Social Science Analyst*, Demographic and Behavioral Sciences Branch, National Institute of Child Health and Human Development, Rockville, Md.

Edited and helped write branch funding announcements and requests for applications. Conducted statistical analyses for members of the branch and in response to outside requests.

9/1995–6/2003 *Computer Consultant*, Baltimore and New York

Designed customized spreadsheet applications to track foundation asset growth and purchasing power. Created web sites for nonprofit groups.

6/1995–12/1998 *Research Analyst/Interim Program Officer*, Health and Human Services division, The Abell Foundation, Baltimore

Reviewed and made recommendations on grant proposals; monitored ongoing grants. Oversaw a survey of adolescent pregnancy prevention service providers in Baltimore and wrote report on findings.

9/1995–12/1995 *Teaching Assistant*, Professor Nan Astone, Sociology of Population course, Department of Population Dynamics, The Johns Hopkins University School of Hygiene and Public Health, Baltimore

9/1994–6/1995 *Research Assistant*, Professor Nan Astone, Department of Population Dynamics, The Johns Hopkins University School of Hygiene and Public Health, Baltimore

7/1993–8/1994 *Crossword Editor,* Dell Champion Crosswords, New York

Constructed and edited crossword puzzles for publication in Dell's crossword publications.

12/1993–8/1994 *Shareholder Relations Writer*, Morgan Guaranty Trust Company,

J.P. Morgan & Co. Incorporated, New York

9/1991–12/1993 *Marketing Assistant*, J.P. Morgan Investment Management, J.P. Morgan & Co. Incorporated, New York

Edited and oversaw design and production of quarterly reports and monthly fact sheets for mutual fund clients. Responded to requests for proposals from existing and potential corporate asset management clients. Wrote custom computer applications to manage proposal tracking and retrieval.

Honors

Named in Thomson Reuters' Highly Cited Researchers 2014

Visiting Professorship in Family Planning, University of Utah School of Medicine, 2014

Alan F. Guttmacher Lectureship, Association of Reproductive Health Professionals, 2012

Ortho-McNeil Best Scientific Paper Award, National Abortion Federation annual meetings, 2005 and 2003 (award funds donated to charity)

Outstanding Young Professional Award, Population, Family Planning and Reproductive Health Section, American Public Health Association, 2004

C. Esther and Paul A. Harper Endowment Award, Department of Population Dynamics, The Johns Hopkins University School of Hygiene and Public Health, 2000

Martha Pines Prize in Bioethics, The Johns Hopkins University School of Hygiene and Public Health, 1998

Delta Omega Public Health Honor Society, The Johns Hopkins University School of Hygiene and Public Health, 1998

Carl Schultz Fellowship, Department of Population Dynamics, The Johns Hopkins University School of Hygiene and Public Health, 1998

National Institute of Child Health and Human Development predoctoral training grant fellowship in demography, 1994–1997

David McCord Prize for Artistic Achievement, Lowell House, Harvard University, 1991

Service to the field

Journals

Member of the editorial board of *Demography*, 2013–present

Member of the editorial board of *Contraception*, 2011–present

Peer reviewer since 2000 for:

American Journal of Obstetrics and Gynecology
American Journal of Public Health
American Sociological Review
Canadian Medical Association Journal
Contraception
Demographic Research
Demography
Human Reproduction
International Journal of Gynecology & Obstetrics
JAMA
Journal of Adolescent Health
Journal of the American Medical Women's Association
Journal of Health Care for the Poor and Underserved
Journal of Women, Politics and Policy
Journal of Women's Health
Maternal and Child Health Journal
Medical Science Monitor
Pediatrics
Perspectives on Sexual and Reproductive Health
Population and Development Review
Reproductive Health Matters
Studies in Family Planning
Women's Health Issues

Other service

Member of Planned Parenthood Federation of America's External Research Advisory Committee, 2015–present

Research proposal reviewer for the Fellowship in Family Planning, 2009–present

Member of the National Campaign to Prevent Teen and Unplanned Pregnancy's Research Advisory Panel, 2007–present

Peer reviewer for the Social Science and Population Studies study section, National Institutes of Health, 2006, 2008, and 2015–2017

Member of the board of directors of the Reproductive Health Technologies Project, 2013–2017; nominating committee member, 2014–2017

Member of the board of directors of the Society of Family Planning, 2008–2014

Member of the advisory panel for the Brookings Institution's Social Genome Project, 2010–2013

Member of the National Center for Health Statistics program review panel for the National Survey of Family Growth, 2010

Liaison member of Planned Parenthood Federation of America's National Medical Committee, 2001–2010

Section Secretary for the Population, Reproductive and Sexual Health Section of the American Public Health Association, 2005–2006; Section Councilor, 2001–2004

Professional affiliations

American Public Health Association (Population, Reproductive and Sexual Health Section)

Population Association of America

Society of Family Planning (charter member)

Skills

Strong proficiency, including extensive programming experience, in a wide variety of statistical, spreadsheet, and database software applications

Strong proficiency in Spanish; beginning French

Publications

Manuscripts in preparation

Teitler JO, Finer LB, Ingerick M, Lindberg LD. Comparing adolescent and young adult fertility trends, 1969–2015. In preparation for the 2018 annual meeting of the Population Association of America.

Manuscripts under review

Finer LB, Lindberg LD, Desai S. A prospective measure of unintended pregnancy in the United States. Submitted to *Contraception*.

Zolna MR and **Finer LB**. Intended pregnancies among women obtaining abortions in the United States: testing for difference and equivalence in abortion patient and population-based surveys. Revise and resubmit at *Contraception*.

Peer-reviewed publications

Sundaram A, Vaughan B, Kost K, Bankole A, **Finer LB**, Singh S and Trussell J. Contraceptive Failure in the United States: Estimates from the 2006–2010 National Survey of Family Growth. *Perspectives on Sexual and Reproductive Health*, 2017, published online. DOI: 10.1363/psrh.12017

Finer LB and Zolna MR. Declines in unintended pregnancy in the United States, 2008–2011. *New England Journal of Medicine*, 2016, 374 (9): 843–852. DOI: 10.1056/NEJMsa1506575

Bearak JM, **Finer LB**, Kavanaugh ML and Jerman J. Changes in out-of-pocket costs for hormonal IUDs after implementation of the Affordable Care Act: an analysis of insurance benefit inquiries. *Contraception*, 2016, 93 (2): 139–144. DOI: 10.1016/j.contraception.2015.08.018

Kavanaugh ML, Jerman J and **Finer LB**. Changes in use of long-acting reversible contraceptive methods among United States women, 2009–2012. *Obstetrics & Gynecology*, 2015, 126 (5): 917–927. DOI: 10.1097/AOG.0000000000001094

Tapales A and **Finer LB.** Unintended pregnancy and the changing demography of American women, 1987–2008. *Demographic Research*, 2015, 33 (article 45): 1241–1254. DOI: 10.4054/DemRes.2015.33.45

- Recipient of *Demographic Research*'s Editor's Choice award.

Sedgh G, **Finer LB**, Bankole A, Eilers MA and Singh S. Adolescent pregnancy, birth and abortion rates across countries: levels and recent trends. *Journal of Adolescent Health*, 2015, 56: 223–230. DOI: 10.1016/j.jadohealth.2014.09.007

Sonfield A, Jones RK, Tapales A and **Finer LB**. Impact of the federal contraceptive coverage guarantee on out-of-pocket payments for contraceptives: 2014 update. *Contraception*, 2014, 91 (1): 44–48. doi:10.1016/j.contraception.2014.09.006

Frost JJ, Sonfield A, Zolna MR and **Finer LB**. Return on investment: a fuller assessment of the benefits and cost-savings of the U.S. publicly funded family planning program. *Milbank Quarterly*, 2014, 92 (4): 667–720. doi:10.1111/1468-0009.12080

Finer LB and Philbin JM. Trends in ages at key reproductive transitions in the United States, 1951–2010. *Women's Health Issues*, 2014, 24 (3): e271–e279. doi:10.1016/j.whi.2014.02.002

- Included in *WHI*'s 25th Anniversary Collection.
- Recognized in *WHI*'s top cited 2014.

Finer LB and Zolna MR. Shifts in intended and unintended pregnancies in the United States, 2001–2008. *American Journal of Public Health*, 2014, 104 (S1): S43–S48. doi:10.2105/ajph.2013.301416

Finer LB, Sonfield A and Jones RK. Changes in out-of-pocket payments for contraception by privately insured women during implementation of the federal contraceptive coverage requirement. *Contraception*, 2014, 89 (2): 97–102. doi:10.1016/j.contraception.2013.11.015

Finer LB and Philbin JM. Sexual initiation, contraceptive use and pregnancy among young adolescents. *Pediatrics*, 2013, 131 (5): 886–891. doi:10.1542/peds.2012-3495

Frost JJ, Lindberg LD and **Finer LB**. Young adults' contraceptive knowledge, norms and attitudes and their association with risk for unplanned pregnancy. *Perspectives on Sexual and Reproductive Health*, 2012, 44 (2): 107–116. doi:10.1363/4410712

Finer LB, Jerman J and Kavanaugh ML. Changes in use of long-acting contraceptive methods in the U.S., 2007–2009. *Fertility and Sterility*, 2012, 98 (4): 893–897. doi:10.1016/j.fertnstert.2012.06.027

Kost K, **Finer LB** and Singh S. Variation in state unintended pregnancy rates in the United States. *Perspectives on Sexual and Reproductive Health*, 2012, 44 (1): 57–64. doi:10.1363/4405712

Steinberg JR and **Finer LB**. Examining the association of abortion history and current mental health: a reanalysis of the National Comorbidity Survey using a common-risk-factors model. *Social Science & Medicine*, 2011, 72 (1): 72–82. doi:10.1016/j.socscimed.2010.10.006

See also: Coleman PK, Coyle CT, Shuping M and Rue VM, Induced abortion and anxiety, mood, and substance abuse disorders: Isolating the effects of abortion in the national comorbidity survey, *Journal of Psychiatric Research*, 2009, 43 (8): 770–776. doi:10.1016/j.jpsychires.2008.10.009

See also: Coleman PK, Coyle CT, Shuping M and Rue VM, Corrigendum to "Induced abortion and anxiety, mood, and substance abuse disorders: Isolating the effects of abortion in the national comorbidity survey," Journal of Psychiatric Research, 2011, 45 (8): 1133–1134. doi:10.1016/j.jpsychires.2011.06.010

Steinberg JR and **Finer LB.** Coleman, Coyle, Shuping, and Rue make false statements and draw erroneous conclusions in analyses of abortion and mental health using the National Comorbidity Survey. *Journal of Psychiatric Research*, 2012, 46:407–408. doi:10.1016/j.jpsychires.2012.01.019

See also: Coleman PK, Response to Dr Steinberg and Dr Finer's letter to the Editor, *Journal of Psychiatric Research*, 2012, 46:408–409. doi:10.1016/j.jpsychires.2012.01.020

See also: Kessler R and Schatzberg A, Commentary on abortion studies of Steinberg and Finer and Coleman, *Journal of Psychiatric Research*, 2012, 46: 410–411. doi:10.1016/j.jpsychires.2012.01.021

Jones RK and **Finer LB**. Who has second-trimester abortions in the United States? *Contraception*, 2012, 85 (6): 544–551. doi:10.1016/j.contraception.2011.10.012

Finer LB and Zolna MR. Unintended pregnancy in the United States: incidence and disparities, 2006. *Contraception*, 2011, 84 (5): 478–485. doi:10.1016/j.contraception.2011.07.013

Kavanaugh MK, Jerman J, Hubacher D, Kost K and **Finer LB**. Characteristics of women in the United States who use long-acting reversible contraceptive methods. *Obstetrics & Gynecology*, 2011, 117 (6): 1349–1357. doi:10.1097/AOG.0b013e31821c47c9

Kapadia F, **Finer LB** and Klukas E. Associations between perceived partner support and relationship dynamics with timing of pregnancy termination. *Women's Health Issues*, 2011, 21 (3 Suppl): S8–S13. doi:10.1016/j.whi.2011.02.005

Kavanaugh MK, Jones RK and **Finer LB**. Perceived and insurance-related barriers to the provision of contraceptive services in U.S. abortion care settings. *Women's Health Issues*, 2011, 21 (3 Suppl): S26–S31. doi:10.1016/j.whi.2011.01.009

Finer LB and Kost K. Unintended pregnancy rates at the state level. *Perspectives on Sexual and Reproductive Health*, 2011, 43 (2): 78–87. doi:10.1363/4307811

Sonfield A, Gold RB, Kost K and **Finer LB**. The public costs of births from unintended pregnancies: national and state-level estimates. *Perspectives on Sexual and Reproductive Health*, 2011, 43 (2): 94–102. doi:10.1363/4309411

Landry DJ, Lindberg LD, Gemmill A, Boonstra H and **Finer LB**. Review of the role of faith- and community-based organizations in comprehensive sex education for adolescents. *American Journal of Sexuality Education*, 2011, 6 (1): 75–103. doi:10.1080/07370008.2010.547372

Kittur ND, Secura GM, Peipert JF, Madden T, **Finer LB** and Allsworth JE. Comparison of contraceptive use between the Contraceptive CHOICE Project and state and national data. *Contraception*, 2011, 83 (5): 479–485. doi:10.1016/j.contraception.2010.10.001

Hubacher D, **Finer LB** and Espey E. Renewed interest in intrauterine contraception in the United States: evidence and explanation. *Contraception*, 2010, 83 (4): 291–294. doi:10.1016/j.contraception.2010.09.004

Kavanaugh ML, Jones RK and **Finer LB**. How commonly do U.S. abortion clinics offer contraceptive services? *Contraception*, 2010, 82 (4): 331–336. doi:10.1016/j.contraception.2010.04.010

Finer LB, Astone NM and Valente TW. Reproductive health policy and interstate influence. *Connections*, 2010, 30 (1): 29–45.

Finer LB. Unintended pregnancy among U.S. adolescents: accounting for sexual activity. *Journal of Adolescent Health*, 2010, 47 (3): 312–314. doi:10.1016/j.jadohealth.2010.02.002

Finer LB and Wei J. Effect of mifepristone on abortion access in the United States. *Obstetrics & Gynecology*, 2009, 114 (3): 623–630. doi:10.1097/AOG.0b013e3181b2a74d

Santelli JS, Lindberg LD, Orr MG, **Finer LB** and Speizer I. Toward a multidimensional measure of pregnancy intentions: evidence from the United States. *Studies in Family Planning*, 2009, 40 (2): 87–100. doi:10.1111/j.1728-4465.2009.00192.x

Jones RK, Kost K, Singh S, Henshaw SK and **Finer LB**. Trends in abortion in the United States. *Clinical Obstetrics and Gynecology*, 2009, 52 (2): 119–129. doi:10.1097/GRF.0b013e3181a2af8f

Frost JJ, **Finer LB** and Tapales A. The impact of publicly funded family planning clinic services on unintended pregnancies and government cost savings. *Journal of Health Care for the Poor and Underserved*, 2008, 19 (3): 778–796. doi:10.1353/hpu.0.0060

Santelli JS, Lindberg LD, **Finer LB** et al. Comparability of contraceptive prevalence estimates for women from the 2002 Behavioral Risk Factor Surveillance System. *Public Health Reports*, 2008, 123 (2): 147–154.

Jones RK, Zolna MRS, Henshaw SK and **Finer LB**. Abortion in the United States: Incidence and access to services, 2005. *Perspectives on Sexual and Reproductive Health*, 2008, 40 (1): 6–16.

Frost JJ, Singh S and **Finer LB**. Factors associated with contraceptive use and nonuse, United States, 2004. *Perspectives on Sexual and Reproductive Health*, 2007, 39 (2): 90–99.

Frost JJ, Singh S and **Finer LB**. U.S. women's one-year contraceptive use patterns, 2007. *Perspectives on Sexual and Reproductive Health*, 2007, 39 (1): 48–55.

Finer LB. Trends in premarital sex in the United States, 1954–2003. *Public Health Reports*, 2007, 122 (1): 73–78.

Santelli JS, Lindberg LD, **Finer LB** and Singh S. Explaining recent declines in adolescent pregnancy in the United States: the contribution of abstinence and improved contraceptive use. *American Journal of Public Health*, 2007, 97 (1): 150–156.

See also: Santelli JS, Lindberg LD, **Finer LB** and Singh S. The roles of abstinence and contraception in declining pregnancy rates. *American Journal of Public Health*, 2007, 97 (6): 969–970 [response to letter by Mann JR and Stine C, *AJPH*, 2007, 97 (6): 969].

Finer LB, Frohwirth LF, Dauphinee LA, Singh S and Moore AM. Timing of steps and reasons for delays in obtaining abortions in the United States. *Contraception*, 2006, 74 (4): 334–344. doi:10.1016/j.contraception.2006.04.010

Finer LB and Henshaw SK. Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *Perspectives on Sexual and Reproductive Health*, 2006, 38 (2): 90–96. doi:10.1363/3809006

Finer LB, Frohwirth LF, Dauphinee LA, Singh S and Moore AM. Reasons U.S. women choose abortion: quantitative and qualitative perspectives. *Perspectives on Sexual and Reproductive Health*, 2005, 37 (3): 110–118. doi:10.1363/3711005

Jones RK, Purcell A, Singh S and **Finer LB**. Adolescents' reports of parental knowledge of adolescents' use of sexual health services and their reactions to mandated parental notification for prescription contraception. *Journal of the American Medical Association*, 2005, 293 (3): 340–348.

Darroch JE, **Finer LB**, Henshaw SK and Jones RK. A history of induced abortion in relation to substance abuse during subsequent pregnancies carried to term. *American Journal of Obstetrics and Gynecology*, 2003, 189 (2): 617–618. [Letter in response to: Coleman PK et al. *AJOG*, 2002, 187 (6): 1673–1678].

Finer LB, Darroch JE and Frost JJ. Services for men at publicly funded family planning agencies, 1998–1999. *Perspectives on Sexual and Reproductive Health*, 2003, 35 (5): 202–207. doi:10.1363/3520203

Finer LB and Henshaw SK. Abortion incidence and services in the United States in 2000. *Perspectives on Sexual and Reproductive Health*, 2003, 35 (1): 6–15. doi:10.1363/3500603

Henshaw SK and **Finer LB**. The accessibility of abortion services in the United States, 2001. *Perspectives on Sexual and Reproductive Health*, 2003, 35 (1): 16–24.

Finer LB, Darroch JE and Frost JJ. U.S. agencies providing publicly funded family planning services in 1999. *Perspectives on Sexual and Reproductive Health*, 2002, 34 (1): 15–24.

Finer LB, Darroch JE and Singh S. Sexual partnership patterns as a behavioral risk factor for sexually transmitted diseases. *Family Planning Perspectives*, 1999, 31 (5): 228–236.

Finer LB and Zabin LS. Does the first family planning visit still matter? *Family Planning Perspectives*, 1998, 30 (1): 30–33 and 42.

Other publications

Finer LB. Innovative birth control options exist, we just need to use them. *New York Times*, Room for Debate, January 1, 2014.

Hussain R and **Finer LB**. Unintended pregnancy and unsafe abortion in the Philippines: context and consequences. In Brief, New York: Guttmacher Institute, 2013, No. 3.

Finer LB and Sonfield A. The evidence mounts on the benefits of preventing unintended pregnancy [editorial]. *Contraception*, 2013, 87 (2): 126–127. doi:10.1016/j.contraception.2012.12.005

Jones RK and **Finer LB**. So, who has second-trimester abortions? *Conscience*, 2012, 33 (1): 22–23.

Finer LB. The decision on the morning-after pill. *New York Times*, December 9, 2011, page A38. [Letter in response to: Harris G. Plan to widen availability of morning-after pill is rejected. *New York Times*, December 8, 2011, page A1].

Henshaw SK, Joyce TJ, Dennis A, **Finer LB** and Blanchard K. Restrictions on Medicaid funding for abortions: a literature review. New York: Guttmacher Institute, 2009.

Joyce TJ, Henshaw SK, Dennis A, **Finer LB** and Blanchard K. The impact of state mandatory counseling and waiting period laws on abortion: a literature review. New York: Guttmacher Institute, 2009.

Dennis A, Henshaw SK, Joyce TJ, **Finer LB** and Blanchard K. The impact of laws requiring parental involvement for abortion: a literature review. New York: Guttmacher Institute, 2009.

Jones RK, **Finer LB** and Singh S. Characteristics of U.S. abortion patients, 2008. New York: Guttmacher Institute, May 2010.

Jones RK, Singh S, **Finer LB** and Frohwirth LF. Repeat abortion in the United States. Occasional Report, New York: Guttmacher Institute, 2006, No. 29.

Finer LB and Henshaw SK. Estimates of U.S. abortion incidence, 2001–2003. New York: Guttmacher Institute, 2006.

Boonstra HD, Gold RB, Richards CL and **Finer LB**. *Abortion in women's lives*. New York: Guttmacher Institute, 2006.

Finer LB and Henshaw SK. Estimates of U.S. abortion incidence in 2001 and 2002. New York: The Alan Guttmacher Institute, 2005.

Finer LB. Don't blame birth control for society's ills. *New York Times*, June 11, 1999, page A32. [Letter in response to: Fukuyama F. At last, Japan gets the pill. Is this good news? *New York Times*, June 9, 1999, page A29].

The Abell Foundation. Adolescent pregnancy prevention efforts in Baltimore City. Abell Reports, Baltimore, April 1998.

Presentations

Finer LB, "Unintended pregnancy in the United States: Past, present, and…?", invited presentation to Stony Brook University's Center on Population, Environment, and Health seminar series, Stony Brook, N.Y., May 12, 2016.

Finer LB, "Contraceptive use and unintended pregnancy in the U.S.: Where we are, how we got here, and where we're going," invited presentation, Amazing Alumni lecture series, Department of Population, Family and Reproductive Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, May 6, 2016.

Finer LB, "Trends in unintended pregnancy and abortion in the United States," grand rounds presentation to the Department of Obstetrics and Gynecology at the University of Pennsylvania Health System, Philadelphia, April 16, 2015.

Finer LB, "Demography of contraceptive use, unintended pregnancy and abortion," invited presentation at the Contraception Day portion of the annual meeting of the American Congress of Obstetricians and Gynecologists, Honolulu, October 20, 2014.

Finer LB, Sonfield A, Jones RK and Tapales A, "Trends in cost sharing after implementation of the Affordable Care Act," plenary at the North American Forum on Family Planning, Miami, October 13, 2014.

Finer LB, "IUD use trends and patterns in the U.S.," panel presentation at the North American Forum on Family Planning, Miami, October 12, 2014.

Finer LB, "Intended and unintended pregnancies: the role of socioeconomic inequities," invited presentation at the New York Academy of Science's Conference on Early-Life Influences on Obesity, New York, September 26, 2014.

Finer LB, "Demography of contraceptive use, unintended pregnancy and abortion in the United States," seminar at the CUNY Institute for Demographic Research, New York, September 19, 2014.

Finer LB, "Demography of second-trimester abortion in the United States," invited presentation at the Fellowship in Family Planning annual meeting, Chicago, April 25, 2014.

Finer LB, "Demography of contraceptive use, unintended pregnancy and abortion in the United States," grand rounds presentation as part of the visiting professorship in family planning, University of Utah, February 20, 2014.

Finer LB, "U.S. teenagers: Who's doing what?", invited presentation as part of the visiting professorship in family planning, University of Utah, February 20, 2014.

Finer LB, "Ages at key reproductive health events in the United States," invited presentation at the City University of New York School of Public Health's Epidemiology and Biostatistics seminar series, New York, September 18, 2013.

Finer LB, "Trends in ages at key reproductive transitions in the United States, 1951–2010," invited presentation at the New York University Center for Advanced Social Science Research seminar series, New York, April 17, 2013.

Finer LB and Lindberg LD, "Trends in ages at key reproductive transitions in the United States, 1951–2010," oral presentation at the annual meeting of the American Public Health Association, San Francisco, October 31, 2012.

Finer LB, Jerman J and Kavanaugh ML, "Changes in use of long-acting contraceptive methods in the U.S., 2007–2009," oral presentation at the annual meeting of the American Public Health Association, San Francisco, October 30, 2012.

Finer LB, "Contraceptive use and unintended pregnancy in the U.S.: Where we are, how we got here, and where we're going," Alan F. Guttmacher Lectureship, Association of Reproductive Health Professionals annual meeting, New Orleans, September 22, 2012.

Finer LB, "Unintended pregnancy: Where we are and how we got there," grand rounds presentation to the Department of Health Evidence and Policy at the Mount Sinai School of Medicine, New York, May 29, 2012.

Finer LB, "The tumultuous history of women's and reproductive health in the U.S.," invited lecture to the Heberden Society of the History of Medicine, Weill Cornell Medical College, New York, May 9, 2012.

Finer LB and Darney B, "Objectivity and exceptionality in reproductive health research," panel presentation at the National Abortion Federation's Social Scientists' Networking Meeting, Vancouver, April 22, 2012.

Finer LB, "When 'should' people have sex … and when do they?", New York Family Planning Grand Rounds presentation, New York, April 9, 2012.

Finer LB, Kost K and Zolna MR, "New data on unintended pregnancy in the United States," oral seminar presentation to the Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University, New York, April 18, 2011.

Finer LB and Zolna MR, "Unintended pregnancy: new estimates for the United States," poster presentation at the annual meeting of the American Public Health Association, Denver, November, 2010.

Finer LB and Zolna MR, "Unintended pregnancy: new estimates for the United States," invited late-breaking oral presentation at the Reproductive Health 2010 conference, Atlanta, September 25, 2010.

Finer LB, "Unplanned and teen pregnancy worldwide: incidence and impact," invited panel presentation at World Contraception Day 2010 launch, London, September 16, 2010.

Finer LB, "Sexual and reproductive health behaviors in the United States: New data from the National Survey of Family Growth," oral presentation at the XIth European Society of Contraception Congress, The Hague, May 20, 2010.

Finer LB, discussant for panel entitled "Fertility intentions, reproductive health and fertility," annual meeting of the Population Association of America, Dallas, April 17, 2010.

Finer LB and Cats-Baril D, "At what age 'should' people start having sex?", oral seminar presentation to the Gender, Sexuality and Health track at the Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University, New York, March 23, 2010.

Finer LB, "Promoting sexual and reproductive health advances maternal and child health," invited plenary presentation at the CDC's Fifteenth Annual Maternal and Child Health Epidemiology Conference, Tampa, December 10, 2009.

Finer LB and Kost K, "Unintended pregnancy levels and trends in the American states," oral presentation at the annual meeting of the American Public Health Association, Philadelphia, November 11, 2009.

Finer LB and Kost K, "Unintended pregnancy in the U.S. at the state level," poster presentation at the Reproductive Health 2009 conference, Los Angeles, October 2, 2009.

Finer LB and Kost K, "Unintended pregnancy in the American states," poster presentation at the annual meeting of the Population Association of America, Detroit, May 1, 2009.

Finer LB and Frost JJ, "Improving Contraceptive Use," invited presentation at the Contraceptive Technology Conference, Washington, D.C., April 4, 2009.

Finer LB, "Sexual and reproductive health: five decades of change," invited presentation at the SUNY Downstate Family Planning Conference, October 2, 2008.

Finer LB, Frost JF and Tapales A, "The impact of publicly funded contraceptive services on unintended pregnancy," invited presentation at the annual meeting of the Association of Reproductive Health Professionals, Washington, D.C., September 19, 2008.

Finer LB, "Statistical tests: what they are, why do them," invited presentation at the annual meeting of the Association of Reproductive Health Professionals, Washington, D.C., September 17, 2008.

Finer LB, "Unintended pregnancy in Iowa: the numbers and the people," invited presentation to the Iowa Initiative to Prevent Unintended Pregnancy, Des Moines, June 11, 2008.

Finer LB, Lindberg LD and Stokes-Prindle C, "Rethinking measures of pregnancy wantedness," oral presentation at the annual meeting of the Population Association of America, New Orleans, April 18, 2008.

Finer LB and Wei J, "Mifepristone's impact on abortion provision in the United States," oral presentation at the annual meeting of the National Abortion Federation, Minneapolis, Minn., April 7, 2008.

Finer LB and Wei J, "Mifepristone provision and use in the United States, 2000–2007," oral presentation at the annual meeting of the American Public Health Association, Washington, D.C., November 7, 2007.

Finer LB, "Understanding the scientific literature: Populations, samples, surveys, and statistical significance," invited presentation at the annual meeting of the Association of Reproductive Health Professionals, Washington, D.C., September 26, 2007.

Finer LB and Dauphinee LA, "Ages at reproductive health transitions in the United States," poster presentation at the annual meeting of the Population Association of America, New York, March 29, 2007.

Finer LB, "Reproductive health in the United States: birth control, unintended pregnancy and abortion," oral presentation at Planned Parenthood of New York City's Board of Directors and Council of Advocates' Meeting, New York, September 28, 2006.

Finer LB and Henshaw SK, "New data on unintended pregnancy in the United States," oral seminar presentation to the Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University, New York, April 17, 2006.

Finer LB, "An overview of abortion demography," lecture in course entitled Public Health Aspects of Reproductive Health Care, Mailman School of Public Health, Columbia University, New York, February 24, 2006.

Henriquez S, Finer LB and Frost JJ, "Research to response: implications of knowledge gaps in Latina sexual and reproductive health," oral presentation at the Office of Minority Health's National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health, Washington, January 9, 2006.

Santelli JS, Lindberg LD, Finer LB and Singh S, "Trends in adolescent sexual experience, contraceptive use, and pregnancy risk, 1995 and 2002," oral presentation at the annual meeting of the American Public Health Association, Philadelphia, December 13, 2005.

Finer LB and Henshaw SK, "Unintended pregnancy in the United States, 1994–2001," poster presentation at the annual meeting of the Association of Reproductive Health Professionals, St. Petersburg, Fla., September 9, 2005.

Finer LB, "Consecuencias físicas y psicológicas del aborto: respuestas a la nueva investigación" ["Physical and psychological consequences of abortion: responses to new research"], oral presentation at the Second Conference on Unwanted Pregnancy and Unsafe Abortion: Public Health Challenges in Latin America and the Caribbean, Mexico City, August 18, 2005.

Finer LB, Frohwirth LF, Dauphinee LA, Singh S and Moore A, "Reasons U.S. women choose abortion: quantitative and qualitative perspectives," oral presentation at the annual meeting of the National Abortion Federation, Montreal, April 18, 2005.

Finer LB, "Reproductive health in the twenty-first century," participation in a panel discussion sponsored by the Radcliffe Institute, New York, April 6, 2005.

Finer LB and Dauphinee LA, "Reasons U.S. women choose abortion: quantitative and qualitative perspectives," oral presentation at the annual meeting of the Population Association of America, Atlanta, April 1, 2005.

Finer LB, "Obtaining an abortion in the U.S.: reasons and process," oral presentation at the annual meeting of the American Public Health Association, Washington, November 9, 2004.

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Finer LB and Dauphinee LA, "Reasons U.S. women choose abortion," poster presentation at the annual meeting of the Association of Reproductive Health Professionals, Washington, September 10, 2004.

Finer LB, "The logistics of obtaining an abortion in the United States," oral presentation at the annual meeting of the National Abortion Federation, New Orleans, April 19, 2004.

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Finer LB, "The determinants and the consistency of reproductive health policymaking in the American states," oral presentation at the annual meeting of the American Public Health Association, Chicago, November 9, 1999.

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XAVIER BECERRA, SBN 118517
Attorney General of California
JULIE WENG-GUTIERREZ, SBN 179277
Senior Assistant Attorney General
R. MATTHEW WISE, SBN 238485
KARLI EISENBERG, SBN 281923
MICHELE L. WONG, SBN 167176
Deputy Attorneys General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-6046
Fax: (916) 324-8853
E-mail: Matthew.Wise@doj.ca.gov
Attorneys for Plaintiff State of California, by and through Attorney General Xavier Becerra

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA, Plaintiff, **v.** **DON J. WRIGHT, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF LABOR; U.S. DEPARTMENT OF LABOR; STEVEN MNUCHIN, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF THE TREASURY; U.S. DEPARTMENT OF THE TREASURY; DOES 1-100,** Defendants.	3:17-cv-05783 **DECLARATION OF DAVE JONES, INSURANCE COMMISSIONER OF CALIFORNIA, IN SUPPORT OF STATE OF CALIFORNIA'S COMPLAINT FOR DECLARATIVE AND INJUNCTIVE RELIEF**

I, Dave Jones, declare:

1. I am over the age of eighteen. I have first-hand knowledge of the matters declared to herein, and am competent to testify as to those facts, except as to the matters declared to on the basis of information and belief and, as to the latter matters, have a reasonable basis to believe them to be true.

2. I am the elected Insurance Commissioner of the State of California. I was first elected in November of 2010, and was re-elected in November of 2014. As Insurance Commissioner, I oversee the California Department of Insurance ("CDI"). Insurers collect $289 billion a year in premiums in California, making it the nation's largest insurance market. California is the also largest health insurance market in the country. CDI has regulatory jurisdiction over health insurers and health insurance coverage in California.

3. Based on my knowledge and experience as the state's insurance regulator, I believe that the Interim Final Rules ("IFRs") will result in women losing access to contraceptives and an increase in unintended pregnancies, abortions, and increased social and economic costs.

4. CDI licenses companies that provide Administrative Services Only ("ASO") plans to self-insured employers. Based on information submitted to and available to CDI, there are approximately 6.6 million covered lives in employer self-funded health plans in California.

5. Californians have a constitutionally guaranteed right to privacy. The IFRs threaten the ability of women to exercise their right to privacy.

6. The California State Legislature, in which I served for six years, found and declared that every individual possesses a fundamental right of privacy with respect to personal reproductive decisions and that California has a long history of expanding timely access to birth control to prevent unintended pregnancy.

7. CDI receives consumer calls, requests for information and complaints about health insurance coverage issues, and provides consumer protection services and information to health insurance policyholders and consumers with self-insured group coverage.

8. As Insurance Commissioner, my responsibilities include implementing and enforcing the Patient Protection and Affordable Care Act ("ACA") and related state laws in California's health insurance market, which I have done since I was sworn into office.

9. As Insurance Commissioner, I have directed CDI staff to ensure compliance with 42 U.S.C. 300gg-13(a)(4), incorporated into state law at section 10112.2 of the Insurance Code, which requires self-insured employer plans and group and individual health insurance policies to cover women's preventive health care services, including contraceptive coverage, with no cost-sharing.

10. As Insurance Commissioner, I have directed CDI staff to enforce state laws, including California Insurance Code section 10123.196(b), which states in part that "[a] group or individual policy of disability insurance, except for a specialized insurance policy, that is issued, amended, renewed, or delivered on or after January 1, 2016, shall provide coverage for all of the following services and contraceptive methods for women: …all FDA-approved, contraceptive drugs, devices, and other products for women…, [v]oluntary sterilization procedures…, [p]atient education and counseling on contraception…, [f]ollowup services related to the drugs, devices, products, and procedures covered under this subdivision, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal." State law requires all non-grandfathered health insurance policies to provide this coverage with no cost-sharing, while grandfathered policies must provide the same coverage but can impose cost sharing. Cal. Ins. Code § 10123.196(b)(2)(A).

11. Subdivision (e) of section 10123.196 includes a narrow religious employer exemption that applies only to nonprofit churches, their integrated auxiliaries, conventions or associations of churches, and the exclusively religious activities of any religious order. The constitutionality of the state contraceptive mandate as applied to religious employers that do not satisfy the exemption was upheld by the California Supreme Court in *Catholic Charities of Sacramento, Inc. v. Superior Court* (2004) 32 Cal.4th 527.

12. California Insurance Code section 10123.196 ensures that the vast majority of Californians covered by fully-insured, non-grandfathered group or individual health insurance policies will continue to have access to the full range of contraceptive products and services without cost-sharing, regardless of any changes to federal law. State law enacted prior to the passage of the ACA also required individual and group health insurance policies that covered prescription drugs to cover a variety of contraceptive methods. However, section 10123.196 does not protect the approximately 6.6 million Californians who are covered by a self-insured employer's health plan.

13. In addition to female employees of self-insured employers being at risk of losing access to contraceptives under the IFRs, the female dependents of employees also stand to lose access to contraceptives.

14. Of the sexually active women of reproductive age in the United States, 99% of these women report having used at least one method of contraception.[1]

15. After the requirement in the ACA for self-insured employer plans and non-grandfathered health insurance to cover preventive health care services without cost-sharing went into effect, CDI staff and I heard from women who said that prior to contraceptives being

[1] Kimberly Daniels, et al., *Contraceptive Methods Women Have Ever Used: United States, 1982-2010*, National Health Statistics Reports No. 62, 1 (Feb. 14, 2013), http://www.cdc.gov/nchs/data.nhsr/nhsr062.pdf.

available without co-pays or deductibles, there were months when they had been unable to afford to fill their prescriptions for contraceptives. If the IFRs are not declared invalid, some women covered by self-insured employer plans will quickly lose access to contraceptives, which will result in unintended pregnancies.[2]

16. As Senate Bill 999 was being considered by the Legislature in 2016, women came forward to tell their personal stories about how skipping just a few pills because they were not able to fill their prescriptions on time resulted in unintended pregnancies and abortions.

17. The near-universal use of contraception among U.S. women includes women who identify as religious. Among all Catholic women who have had sex, 98% have used some form of modern contraception at some point in their lives. Among women of all denominations, more than two-thirds of sexually active women use highly effective methods of contraception such as sterilization, hormonal birth control pills, or an intra-uterine device ("IUD").[3]

18. Unplanned or unintended pregnancy can lead to many adverse medical outcomes for both the woman and the baby.[4,5,6]

19. Some women who lose access to insurance coverage for contraceptives due to the IFRs will seek contraceptive services from a Family PACT provider. However, these services

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[2] Joerg Dreweke, *New Clarity for the U.S. Abortion Debate: A Steep Drop in Unintended Pregnancy Is Driving Recent Abortion Declines*, Guttmacher Policy Review Vol.19 (2016), https://www.guttmacher.org/sites/default/files/article_files/gpr1901916.pdf.

[3] Rachel K. Jones & Joerg Dreweke, Guttmacher Institute, *Countering Conventional Wisdom: New Evidence on Religion and Contraceptive Use* (2011), https://www.guttmacher.org/sites/default/files/report_pdf/religion-and-contraceptive-use.pdf

[4] Institute of Medicine, *Clinical Preventive Services for Women: Closing the Gaps* ("IOM Report") (2011).

[5] Claudia Goldin & Lawrence F. Katz, *The Power of the Pill: Oral Contraceptives and Women's Career and Marriage Decisions,* 110 J. of Pol. Econ. (2002), http://nrs.harvard.edu/urn-3:HUL.InstRepos:2624453

[6] Heinrich H. Hock, *The Pill and the College Attainment of American Women and Men*, (Fla. State Univ., Working Paper 2007)

are not without cost to the woman, and they are limited only to low-income women, with incomes less than 200% of the Federal Poverty Level ("FPL"). Women with incomes above 200% of FPL will bear the full cost of contraceptive services and products.

20. The average monthly cash price of hormonal birth control pills is between $15 and $80. IUDs carry upfront costs of $500 to $1,000 for the device itself, which does not include the cost of the office visit, insertion, follow-up visits, or removal. IUDs are effective for up to five years. Other long-acting methods such as contraceptive implants cost between $400 and $800, and must be re-inserted every three years. [7]

21. A claims study published in 2015 estimated that due to the ACA's preventive services contraceptive mandate, average out-of-pocket savings per contraceptive user was $248 for insertion of an IUD (a 68% reduction) and $255 annually for the oral contraceptive pill (a 38% reduction). Declines in out-of-pocket spending for other methods of contraception are also significant: 93% for emergency contraceptives, 84% for barrier methods, 72% for the implant, and 68% for the injection.[8]

22. An estimated 6.88 million privately insured women used oral contraceptives in 2013, which based on the 2015 claims study translated into approximately $1.4 billion in savings on out-of-pocket expenses for oral contraceptives alone. By June 2013, a majority of women on private health plans were paying nothing out-of-pocket for their contraception due to the ACA's preventive services contraceptive mandate.[9] These

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[7] Laurie Sobel, et al., Kaiser Family Foundation, *Coverage of Contraceptive Services: A Review of Health Insurance Plans in Five States* (April 16, 2015) http://files.kff.org/attachment/report-coverage-of-contraceptive-services-a-review-of-health-insurance-plans-in-five-states

[8] Becker et al. *Women Saw Large Decrease In Out-Of-Pocket Spending For Contraceptives After ACA Mandate Removed Cost Sharing*, Health Affairs 2015 Jul;34(7):1204-11. Summary available online at https://www.ahcmedia.com/articles/136218-affordable-care-act-makes-impact-on-costs-of-many-forms-of-birth-control.

[9] Rebecka Rosenquist, University of Pennsylvania Leonard Davis Institute of Health (continued...)

statistics demonstrate that women with private insurance, including those covered by self-funded employer plans, have benefited from decreased out-of-pocket costs for contraceptives due to the ACA's contraceptive mandate.

23. Starting in December of 2016 or January of 2017, CDI received calls from women who were concerned that changes at the federal level could impact their access to contraceptive coverage. Women asked questions about whether it would be advisable to fill their prescriptions for contraceptives for a 12-month supply at one time. Women also asked whether to switch methods of birth control from the method they had previously chosen with their physicians in order to have a longer lasting form of contraception in case federal action threatened their access to birth control coverage.

24. Since the announcement of the IFR, the Department has received calls asking which health insurance policies will be impacted and when women will lose their coverage for contraception.

25. Many people whose health coverage is through employers that self-insure do not realize that their coverage is self-funded and consequently that it is not subject to many of the protections in state law, including the contraceptive mandate.

26. Women's access to contraceptives and the potential of unintended pregnancy can impact most every aspect of a woman's life including her education, employment and economic security. The IFRs permit self-insured employers in California to drop coverage for contraceptives without cost-sharing, which will negatively affect women's health, well-being, economic security, and productivity.

(…continued)
Economics, *The ACA and Contraceptive Coverage*, July 7, 2015. Available online at https://ldi.upenn.edu/aca-and-contraceptive-coverage.

I declare under penalty of perjury that the foregoing is true and correct and if called as a witness, I would competently testify thereto.

Executed on October 16, 2017, in Sacramento, California.

Dave Jones
Insurance Commissioner of California

XAVIER BECERRA, SBN 118517
Attorney General of California
JULIE WENG-GUTIERREZ, SBN 179277
Senior Assistant Attorney General
R. MATTHEW WISE, SBN 238485
KARLI EISENBERG, SBN 281923
MICHELE L. WONG, SBN 167176
Deputy Attorneys General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-6046
Fax: (916) 324-8853
E-mail: Matthew.Wise@doj.ca.gov
Attorneys for Plaintiff State of California, by and through Attorney General Xavier Becerra
[Additional counsel listed on next page]

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

THE STATE OF CALIFORNIA, THE STATE OF DELAWARE, THE STATE OF MARYLAND; THE STATE OF NEW YORK, THE COMMONWEALTH OF VIRGINIA,

Plaintiffs,

v.

ERIC D. HARGAN, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF LABOR; U.S. DEPARTMENT OF LABOR; STEVEN MNUCHIN, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF THE TREASURY; U.S. DEPARTMENT OF THE TREASURY; DOES 1-100,

Defendants.

4:17-cv-05783-HSG

DECLARATION OF KAREN NELSON IN SUPPORT OF STATES' MOTION FOR PRELIMINARY INJUNCTION

ATTORNEYS FOR ADDITIONAL PLAINTIFFS

MATTHEW P. DENN
Attorney General of Delaware
AARON R. GOLDSTEIN*
State Solicitor
LAKRESHA S ROBERTS*
Chief Deputy Attorney General
JESSICA M. WILLEY*
Deputy Attorney General
Delaware Department of Justice
820 N. French Street
Wilmington, DE 19801
Attorneys for Plaintiff the State of Delaware

BRIAN E. FROSH
Attorney General of Maryland
STEVE M. SULLIVAN*
Solicitor General
CAROLYN A. QUATTROCKI*
Deputy Attorney General
KIMBERLY S. CAMMARATA*
Director, Health Education and Advocacy
200 St. Paul Place
Baltimore, MD 21202
Attorneys for Plaintiff the State of Maryland

ERIC T. SCHNEIDERMAN
Attorney General of New York
LISA LANDAU*
Bureau Chief, Health Care Bureau
SARA HAVIVA MARK*
Special Counsel
ELIZABETH CHESLER*
Assistant Attorney General
120 Broadway
New York, NY 10271
Attorneys for Plaintiff the State of New York

MARK R. HERRING
Attorney General of Virginia
SAMUEL T. TOWELL*
Deputy Attorney General
202 North Ninth Street
Richmond, VA 23219
Attorneys for Plaintiff the Commonwealth of Virginia

* Pro hac vice application forthcoming

I, Karen Nelson, declare:

1. I am the President and CEO of Planned Parenthood of Maryland, Inc. (PPM). I have been President and CEO of PPM since March 2016. I have worked for Planned Parenthood organizations since 1994, including serving as President and CEO from 2008-2016 for Planned Parenthood of Central and Western New York and its predecessor organization, Planned Parenthood of Western New York.

2. This declaration is based on my professional knowledge, my review of PPM's records, and the knowledge that I have acquired in the 23 years of service with affiliates of Planned Parenthood. If called and sworn as a witness, I could and would testify competently to the information contained in this declaration.

3. There are two Planned Parenthood affiliates that operate health centers in Maryland: PPM and Planned Parenthood of Metropolitan Washington, DC, Inc. (PPMW). PPM and PPMW are separately incorporated entities. PPMW is responsible for services in Montgomery and Prince George's counties, and PPM has responsibility for the rest of the state. Planned Parenthood's mission in Maryland includes providing a wide range of high quality, affordable reproductive health care services; education to empower individuals to make informed reproductive choices; and advocacy to protect the right to make those choices.

4. Collectively, PPM and PPMW currently operate nine health centers and serve more than 36,000 patients each year in Maryland. A map of the locations of Planned Parenthood health centers in Maryland is attached as Exhibit A.

5. The two interim final rules (IFRs), as issued on October 6, 2017 by the U.S Health and Human Services Department, in conjunction with the U.S. Department of Labor and U.S Department of Treasury, would have a devastating impact on some women in Maryland who rely on Planned Parenthood of Maryland for health care services, including contraceptive services. The IFRs would also have a severe impact on the State of Maryland which would have to increase funding for public health programs to ensure women have access to contraceptive services to fill the void filled by employers who refuse to provide insurance coverage that was formerly required by law.

Planned Parenthood's Role in Supporting Patients and Promoting Public Health in Maryland

6. Planned Parenthood provides services to 32% of women who need publicly funded contraceptive services in Maryland.[1] In 2016, Planned Parenthood of Maryland provided services to 26,464 patients in Maryland at its health centers in Annapolis, Baltimore, Easton, Frederick, Owings Mills, Towson, and Waldorf. In 2016, Planned Parenthood of Metropolitan Washington, DC provided services to 9,783 patients in Maryland at its health centers in Gaithersburg, Suitland, and Silver Spring (the Silver Spring location closed in 2017).

7. Both PPM and PPMW provide services to individuals who are uninsured, participate in a Medicaid program, or are covered by private insurance.

8. When patients do not have insurance coverage or have insurance without contraceptive coverage, patients pay a portion of the cost of their care as determined by a sliding fee scale based on income. Planned Parenthood covers the remainder of the cost of care using its own funding as well as grants from the Title X program.

9. In Fiscal Year 2017 (July 2016-June 2017), PPM received $1,704,159 in Title X funds, and in Fiscal Year 2017 (October 2016-September 2017), PPMW received $130,483 in Title X funds. Since the amount of funding is a fixed grant, it cannot increase within the grant year because of increases in patient volume.

10. PPM and PPMW provide reproductive health care services including wellness exams, contraception counseling, breast health exams, cancer screenings, birth control, HPV vaccinations, sexually transmitted infection testing and treatment, pregnancy testing and option counseling, emergency contraception, sterilization, and abortion services.

11. Of the 36,247 patients to whom PPM and PPMW provided services in 2016, 32,979 were female. The payor mix for this group was:

[1] Response to Inquiry Concerning the Availability of Publicly Funded Contraceptive Care to U.S. Women, Guttmacher Institute, May 2017.

a. 10,267 Medicaid patients (including Medicaid, MCHP, and Medicaid Family Planning Program), representing 32% of PPM and 16% of PPMW's patients at Maryland health centers;

b. 7,147 Title X patients, representing 25% of PPM and 5% of PPMW's patients at Maryland health centers;

c. 7,088 patients who receive services, including abortion, not covered under Title X or who fall into a miscellaneous eligibility category, representing 13% of PPM and 39% of PPMW's patients at Maryland health centers; and

d. 11,745 commercially insured patients, representing 30% of PPM and 40% of PPMW's patients at Maryland health centers.

Risk to Planned Parenthood's Insured Patients

12. As noted above, nearly 12,000 of Planned Parenthood's patients at Maryland health centers have commercial insurance. Planned Parenthood patients who are covered by insurance plans which the employer self-funds are at risk for losing contraception coverage under the IFRs because their employers could claim a religious or moral exemption and would not have to seek accommodation if they discontinue coverage. Since 1998, Maryland has mandated that most state-regulated plans cover contraception.[2] In 2016, the Maryland Contraceptive Equity Act broadened coverage requirements for State-regulated plans with contraception coverage.[3] However, self-funded insurance plans are not required to comply with State law, as these plans are exempt from State insurance laws by the federal Employee Retirement Security Act (ERISA).

13. Since the IFRs permit an individual to refuse insurance coverage of contraception, even more of Planned Parenthood's insured patients are at risk. Some patients are not the policy holders of their insurance plans, but rather they are covered under the plans of a parent, spouse, or partner. Women could lose contraceptive coverage because of the religious or moral objections

[2] House Bill 457 – Health Benefit Plans – Coverage for Prescriptive Contraceptives Drugs or Devices, 1998, http://mgaleg.maryland.gov/webmga/frmMain.aspx?tab=subject3&ys=1998rs/billfile/hb0457.htm

[3] House Bill 1005/Senate Bill 848 – Health Insurance – Contraceptive Equity Act, 2016, http://mgaleg.maryland.gov/webmga/frmMain.aspx?id=hb1005&stab=01&pid=billpage&tab=subject3&ys=2016rs

of the policy holder. Women facing domestic violence within their families are also at risk for loss of contraception coverage. If the policy holder is the abuser, that person may discontinue contraceptive coverage. Planned Parenthood has seen many domestic violence victims whose partners or family members try to block access to birth control as part of controlling, abusive behavior.

Increase in Women Seeking Family Planning Services at Planned Parenthood

14. With the IFRs, women in insurance plans which the employer self-funds will be at risk of losing contraceptive coverage. Since approximately 1.46 million Marylanders are covered through self-funded insurance plans, a substantial number of women are at risk for losing contraception coverage.[4] Employers are not required to provide any accommodation if they discontinue contraceptive coverage.

15. Based on my experience and since Planned Parenthood is a trusted provider of reproductive health services, I believe that many women who lose contraceptive coverage will turn to Planned Parenthood sites across the State. Women know that Planned Parenthood's mission is "Care. No matter what." The only systemic options for covering the cost of these services are the Title X Program, the Medicaid Family Planning Program, and Medicaid/MCHP.

Impact to the Title X Program

16. Title X is a federal family planning grant program that in Maryland, is administered by the Maryland Department of Health. Planned Parenthood receives a total of $1,834,641 (PPM and PPMW Fiscal Years 2017). Other Title X providers include local health departments and community health centers. All Title X providers are non-profit organizations or local health departments. The total Maryland budget for Title X is $9.9 million, with $6 million in State funds and $3.3 million in federal funds.[5]

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[4] Maryland Insurance Administration, *2016 Maryland Covered Lives Report* (November 2016), http://insurance.maryland.gov/Consumer/Pages/Life-and-Health-Reports.aspx

[5] Fiscal Note for House Bill 1083 – Family Planning Services, Continuity of Care, Department of Legislative Services, February 2017, http://mgaleg.maryland.gov/2017RS/fnotes/bil_0003/hb1083.pdf

17. The Title X program has been successful in reducing unintended pregnancies in Maryland. In 2014, Title X providers in Maryland were responsible for assisting women in avoiding 14,000 unintended pregnancies.[6]

18. Women with incomes up to 250% of the federal poverty level are eligible for the Title X program. Women who qualify for Title X services may be uninsured or have commercial insurance. For women with insurance, Title X covers family planning services not covered by the individual's insurance policy. All Title X participants, with the exception of those with the lowest income levels, must contribute to the cost of their care according to a sliding fee schedule approved by the Maryland Department of Health.

19. With the IFRs, I believe that there will be an influx of insured patients who will turn to Title X for support when they lose contraception coverage. Planned Parenthood is the largest provider of publicly funded family planning services. In 2015, Planned Parenthood provided contraceptive services to nearly one-third of the women seeking services at publicly funded clinics.[7] I believe that Planned Parenthood will see a large portion of the women seeking services when they lose contraceptive insurance coverage.

20. Title X is funded through a fixed amount in the State budget. I believe that it will be difficult for the current budget levels to accommodate the increase in women seeking support after losing contraception coverage in their insurance plans. The State would have to increase State funding of Title X to ensure that patients across Maryland can be accommodated by the program. Planned Parenthood, as is likely the case with other Title X providers, is not in the position to absorb an influx of new patients into Title X without State financial support.

21. Even if the State were to increase Title X funding, there is still a financial burden on the patient. Prior to the IFRs, insurance plans have been required to provide contraceptive

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[6] *State Facts on Publicly Funded Family Planning Services: Maryland*, Guttmacher Institute, September 2016, https://www.guttmacher.org/fact-sheet/state-facts-publicly-funded-family-planning-services-maryland

[7] Frost et al, "Publicly Funded Contraceptive Services at U.S. Clinics, 2015" Guttmacher Institute, April 2017, https://www.guttmacher.org/sites/default/files/report_downloads/publicly_funded_contraceptive_services_2015_tables_1-7.pdf

counseling and most contraceptive options without copayment. If women lose contraception coverage and turn to Title X, they will have to pay a portion of their costs, based on a sliding fee scale, with the exception of individuals with the lowest-income levels. With cost sharing requirements under a sliding fee scale, contraception may be unaffordable, particularly for more expensive methods such as IUDs.

Impact of Increase of Women Turning to the Medicaid Family Planning Program

22. The Medicaid Family Planning Program is a limited benefits program that covers family planning services. The program is administered by the Maryland Medical Assistance Program. The funding for the Medicaid Family Planning Program is based on volume of services covered, rather than a fixed budget. In fiscal 2016, the State spent $3.2 million on the program, with 10% of funding from general funds and 90% from federal funds.[8] The average monthly enrollment was 12,852. [9] Higher enrollment would lead to an increase in State expenditures.

23. The program provides coverage to uninsured individuals or wrap-around coverage for commercially insured patients. Participants may have incomes up to 200% of the federal poverty level. There are no cost-sharing requirements for participants.

24. Planned Parenthood provides services to women that are covered under the Medicaid Family Planning Program. Because Medicaid claims systems do not distinguish between Medicaid fee-for-service and Medicaid Family Planning, I cannot attest to the number of Planned Parenthood patients covered by this program.

25. Due to the IFRs, I believe that insured patients will seek wrap-around coverage from the Medicaid Family Planning Program. This will result in an increase in State funds needed to support this program.

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[8] Department of Legislative Services, Fiscal Note for House Bill 1083 – Family Planning Services, Continuity of Care, February 2017, http://mgaleg.maryland.gov/2017RS/fnotes/bil_0003/hb1083.pdf

[9] Department of Legislative Services, *Operating Budget Analysis of the Medical Care Programs Administration*, February 2017, http://mgaleg.maryland.gov/pubs/budgetfiscal/2018fy-budget-docs-operating-M00Q01-DHMH-Medical-Care-Programs-Administration.pdf

Impact of Increase of Women and their Families Turning to the Medicaid/MCHP Programs

26. The Maryland Medicaid Program and Medicaid Children's Health Program (MCHP) cover a full range of services, including family planning, to low income women and their families. For Medicaid, participants may have incomes of up to 138% of the federal poverty level. MCHP covers individuals up to age 19 with incomes up to 300% of the federal poverty level. Most Medicaid and MCHP participants receive their coverage through the managed care program called HealthChoice. In calendar year 2016, HealthChoice spent $33.7 million on family planning services with 10% from State funds and 90% in federal funds.[10]

27. Planned Parenthood provides services to a significant number of Medicaid and MCHP participants: nearly 10,000 in 2016 alone.

28. As a result of the IFRs, I believe that some eligible women will forgo employer coverage and enroll in Medicaid or enroll in Medicaid for wrap-around coverage. Women with children may switch their children from their employer's family plans to MCHP or enroll their children for wrap-around coverage. As a result, the cost of coverage will shift from the employer to the State and federal government. Maryland will pay 10% of the cost of family planning services and up to 50% for the cost of other services, depending on the eligibility category of the participant.

Impact on Women without Contraception Coverage

29. "Family planning is one of the 10 great public health achievements of the 20th century. The availability of family planning services allows individuals to achieve desired birth spacing and family size, and contributes to improved health outcomes for infants, children, women, and families," according to Healthy People 2020[11].

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[10] Department of Legislative Services, Fiscal Note for House Bill 1083 – Family Planning Services, Continuity of Care, February 2017, http://mgaleg.maryland.gov/2017RS/fnotes/bil_0003/hb1083.pdf

[11] Healthy People 2020, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning

30. If women who lose contraceptive coverage do not qualify or are unable to obtain coverage under one of the programs I have outlined above, they face a higher risk for unintended pregnancy and associated poor health outcomes. The rate of unintended pregnancy among women who are not using contraception is 45%.[12] Contraception services are basic, preventive health care for women, improve the lives of families, and should be part of insurance coverage.

31. Women at Planned Parenthood frequently tell us that birth control is essential in allowing them to complete their educations, follow their career paths, and make their own choices about if or when to have children.

Creation of a Patchwork System of Coverage

32. Planned Parenthood is dedicated to serving all individuals regardless of income level or insurance status. Planned Parenthood, along with all other health care providers, need a consistent reimbursement system to ensure our patients' needs are met. Contraceptive services are basic preventive health care services, and I believe that they should be part of the continuum of services funded by any health insurer in either the commercial or public markets. If contraceptive coverage is not covered by an employer, only publicly funded programs, such as Title X and Medicaid programs, can provide a consistent reimbursement system for those services. Even then, the coverage system will be compromised, as not all women will meet eligibility requirements for those programs.

33. The proposed IFRs allow employers, individuals, and insurers to separate contraceptive coverage from health care coverage. As a result, the IFRs will create a confusing patchwork insurance system under which most services will be covered by private insurance. However, contraceptive coverage, regardless of whether the patient has employer-based insurance, may be provided by private insurance, a public program, or not at all. The result will be a confusing patchwork of coverage rules that will be difficult for both patients and providers to navigate.

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[12] CHBRP Birth Control Report, at 22, citing Fitner, LB, Zolna MR, Declines in Unintended Pregnancy in the United States, 2008-2011, *New England Journal of Medicine* 374(9):843-552 (2016).

Overall Impact on the State

34. I believe the IFRs create financial risk to the State of Maryland. The State must bear the cost of increasing funding for public programs to ensure that all of its citizens have access to basic, preventive health services. If the State does not increase funding, women will be more at risk for unintended pregnancies, and the State will face the economic consequences of fewer women being able to finish their education and advance in the job market.

35. Finally, I also believe the IFRs will impede efforts to improve the reproductive health of women in Maryland. Rather than using our resources to move forward to improve the health and lives of women in Maryland, we will need to divert resources to backfill contraceptive coverage dropped by employers.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on November 8, 2017, in Baltimore, Maryland.

Karen Nelson

Karen Nelson
President and CEO
Planned Parenthood of Maryland

Exhibit A:

Maryland Planned Parenthood Health Centers

Declaration of Karen J. Nelson, Planned Parenthood of Maryland, November 3, 2017

XAVIER BECERRA, SBN 118517
Attorney General of California
JULIE WENG-GUTIERREZ, SBN 179277
Senior Assistant Attorney General
R. MATTHEW WISE, SBN 238485
KARLI EISENBERG, SBN 281923
MICHELE L. WONG, SBN 167176
Deputy Attorneys General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-6046
Fax: (916) 324-8853
E-mail: Matthew.Wise@doj.ca.gov
Attorneys for Plaintiff State of California, by and through Attorney General Xavier Becerra
[Additional counsel listed on next page]

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

THE STATE OF CALIFORNIA, THE STATE OF DELAWARE, THE STATE OF MARYLAND; THE STATE OF NEW YORK, THE COMMONWEALTH OF VIRGINIA, Plaintiffs, **v.** **ERIC D. HARGAN, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF LABOR; U.S. DEPARTMENT OF LABOR; STEVEN MNUCHIN, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF THE TREASURY; U.S. DEPARTMENT OF THE TREASURY; DOES 1-100,** Defendants.	4:17-cv-05783-HSG **DECLARATION OF KEISHA BATES IN SUPPORT OF STATES' MOTION FOR PRELIMINARY INJUNCTION**

ATTORNEYS FOR ADDITIONAL PLAINTIFFS

MATTHEW P. DENN
Attorney General of Delaware
AARON R. GOLDSTEIN*
State Solicitor
LAKRESHA S ROBERTS*
Chief Deputy Attorney General
JESSICA M. WILLEY*
Deputy Attorney General
Delaware Department of Justice
820 N. French Street
Wilmington, DE 19801
Attorneys for Plaintiff the State of Delaware

BRIAN E. FROSH
Attorney General of Maryland
STEVE M. SULLIVAN*
Solicitor General
CAROLYN A. QUATTROCKI*
Deputy Attorney General
KIMBERLY S. CAMMARATA*
Director, Health Education and Advocacy
200 St. Paul Place
Baltimore, MD 21202
Attorneys for Plaintiff the State of Maryland

ERIC T. SCHNEIDERMAN
Attorney General of New York
LISA LANDAU*
Bureau Chief, Health Care Bureau
SARA HAVIVA MARK*
Special Counsel
ELIZABETH CHESLER*
Assistant Attorney General
120 Broadway
New York, NY 10271
Attorneys for Plaintiff the State of New York

MARK R. HERRING
Attorney General of Virginia
SAMUEL T. TOWELL*
Deputy Attorney General
202 North Ninth Street
Richmond, VA 23219
Attorneys for Plaintiff the Commonwealth of Virginia

* Pro hac vice application forthcoming

I, Keisha Bates, declare:

1. I am a Maryland resident who is currently residing in Baltimore City. Since moving to Maryland, I have worked in basic science research at a neuroscience lab at Johns Hopkins and worked as an admission counselor at the University of Maryland College Park. I also recently graduated from the Clinical Nurse Leader master's program for second degree students at the University of Maryland School of Nursing in May 2017 and am currently working as an inpatient gynecology/perinatal nurse at a large, urban hospital.

2. This declaration is about my personal knowledge about the impact of the interim final rules (IFRs), issued by the U.S. Health and Human Services Department, in conjunction with the U.S. Department of Labor and U.S. Department of Treasury, on October 6, 2017. The IFRs will dramatically reduce access to contraceptive coverage for me and my patients.

3. Contraception coverage is essential to me. Through my current employer, I have contraception coverage. Personally, I medically need hormonal birth control to avoid heavy periods that make me anemic and to prevent debilitating menstrual cramps that used to occur two weeks out of each month and would often keep me home from work. It is incredibly important to me that I continue to maintain my contraception coverage, regardless of where I work. The current IUD I have will expire in two years, and considering the bills and high loan payments that I have, I do not think I would be able to afford the hundreds of dollars it would cost out-of-pocket to get a new IUD without insurance coverage. If I were to get pregnant, or even if my debilitating cramps were to return, I would be greatly hindered not only in my ability to work, but also in my ability to pursue a doctoral degree in the future and become a nurse practitioner.

4. The IFRs personally harm me by limiting my future job choices to employers with contraception coverage, thus decreasing my opportunities for career development and advancement. The IFRs will increase the number of employers who do not offer insurance with contraception coverage. I am particularly worried about this in the health care field, where a large number of facilities and health programs have historical ties to religious institutions. For me, contraceptive coverage to control my menstrual cycle is essential to my livelihood.

5. The IFRs also personally harm me because, at any point in my career, my employer could discontinue contraception coverage when renewing health plans for its employees. This means that I could be put in a difficult position of having to switch employers to get coverage. I probably would not qualify for some of the State family planning programs because of my income level. Yet, as I stated previously, contraception is not affordable to me at this point in my life.

5. As a nurse, I am concerned about the impact of the IFRs on my patients. Pregnancy is a serious medical condition, and it is can be dangerous. I know this because I work with pregnant and postpartum women every day. I see women come close to death because of complications relating to their pregnancy and/or birth. I see women develop health issues that they carry with them for the rest of their lives because of their pregnancy and/or birth. I see women who have to stop taking psychiatric and seizure medications because of pregnancy, placing their lives at risk for over 9 months. I am concerned about the impact of the IFRs on my patients. If their employers drop contraception coverage, they may forgo using contraception and be in a position where their health or life is at risk.

6. Finally, having been raised in the Lutheran faith, I support religious freedom and understand its importance in our society. However, what I cannot support is when the religious or moral beliefs of one individual (or employer) are given the power to take away the rights of another. Contraceptive coverage is essential to me and other women. It's essential to ensure that we are healthy, can plan if and when to have families, finish our education, and obtain employment to become productive citizens.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on November 3, 2017, in Baltimore, Maryland.

Keisha Bates
B.A., M.S., R.N.

XAVIER BECERRA, SBN 118517
Attorney General of California
JULIE WENG-GUTIERREZ, SBN 179277
Senior Assistant Attorney General
R. MATTHEW WISE, SBN 238485
KARLI EISENBERG, SBN 281923
MICHELE L. WONG, SBN 167176
Deputy Attorneys General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-6046
Fax: (916) 324-8853
E-mail: Matthew.Wise@doj.ca.gov
Attorneys for Plaintiff State of California, by and through Attorney General Xavier Becerra

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA; STATE OF NEW YORK; STATE OF DELAWARE; COMMONWEALTH OF VIRGINIA, Plaintiffs, **v.** **DON J. WRIGHT, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF LABOR; U.S. DEPARTMENT OF LABOR; STEVEN MNUCHIN, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF THE TREASURY; U.S. DEPARTMENT OF THE TREASURY; DOES 1-100,** Defendants.	4:17-cv-05783-HSG **DECLARATION OF REVEREND SUSAN RUSSELL IN SUPPORT OF STATES' MOTION FOR PRELIMINARY INJUNCTION**

I, Reverend Susan Russell, declare:

1. I am an ordained Episcopal priest and Senior Associate at All Saints Church in Pasadena, California – a church that has been prayerfully pro-choice since 1992 and a denomination that has supported a woman's access to birth control since the 1930's.

2. The core values of my faith tradition include striving for justice and respecting dignity of every human being. Respecting human dignity requires supporting the choices women make about when and if to become pregnant. The ability to plan, prevent, and space pregnancies is linked to benefits to women, men, children and a just society, including more educational and economic opportunities, healthier babies, more stable families and reduced taxpayer burden.

3. I am a member of the Clergy Advocacy Board of Planned Parenthood. As a member of the Board since 2013 I have been honored to stand with people of faith whose support for reproductive health care is firmly rooted in their faith.

4. The Clergy Advocacy Board builds on the long history of faith leaders taking an active role in reproductive health care and has been working for more than two decades with Planned Parenthood at the national and state levels to further the goal of full reproductive rights and freedom for all women and men. Its members, who are dedicated clergy and faith leaders from different denominations and communities throughout the U.S., lead a national effort to increase public awareness of the theological and moral basis for advocating reproductive health.

5. The Clergy Advocacy Board is called to serve as pastors to people making medical decisions. Our experience teaches that a woman's health care is between her and her doctor. As religious leaders, embracing the truth in faith alongside the truth in medical science, we believe that our households and families should be allowed to benefit from advances in modern day health care, contraception included. Our various faith heritages bring us to teach that the Divine Presence enters and blesses all our relationships, separate and apart from our becoming parents. We affirm that God graces each of us with a conscience that includes the capacity to set the course of our lives and families. All this speaks to why, from the earliest days of the family planning movement in the United States, clergy from a wide spectrum of faiths have embraced family planning as a moral good.

7. For these reasons, the Clergy Advocacy Board condemns the Trump administration's attempts to use morality and religion to undermine access to contraception. Too many families today are facing financial challenges and crises. We believe that every individual should have the religious freedom and freedom of conscience to choose and consistently use the contraception that works best for them.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on 26th day of October 2017 in Pasadena, California.

The Reverend Susan Russell
Clergy Advocacy Board of
Planned Parenthood

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XAVIER BECERRA, SBN 118517
Attorney General of California
JULIE WENG-GUTIERREZ, SBN 179277
Senior Assistant Attorney General
R. MATTHEW WISE, SBN 238485
KARLI EISENBERG, SBN 281923
MICHELE L. WONG, SBN 167176
Deputy Attorneys General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-6046
Fax: (916) 324-8853
E-mail: Matthew.Wise@doj.ca.gov
Attorneys for Plaintiff State of California, by and through Attorney General Xavier Becerra

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA,

Plaintiff,

v.

DON J. WRIGHT, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF LABOR; U.S. DEPARTMENT OF LABOR; STEVEN MNUCHIN, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF THE TREASURY; U.S. DEPARTMENT OF THE TREASURY; DOES 1-100,

Defendants.

4:17-cv-05783-KAW

DECLARATION OF JOHN ARENSMEYER IN SUPPORT OF STATE OF CALIFORNIA'S MOTION FOR PRELIMINARY INJUNCTION

1. I, John Arensmeyer, declare: I am the Founder and CEO of Small Business Majority. I have used my long experience as a business owner to build Small Business Majority into a nationally recognized small business organization and the leading advocate for public policy issues facing America's entrepreneurs. In the past few years I have spearheaded the growth of Small Business Majority's Entrepreneurship Program, providing critical practical resources to our nation's 28 million small businesses.

2. Previously, I was the founder and CEO of ACI Interactive, an award-winning international e- commerce company. Earlier, I served as the chief operating officer of a pioneering multimedia business and as an attorney in New York. In 2009, I served on a panel at the White House summit on healthcare reform. I testify regularly before congressional committees, and have briefed White House officials and congressional leadership on small business policy issues. I serve as Board Chair for California's Insure the Uninsured Project. Previously, I led a study group at Harvard's Kennedy School of Politics, and served on the Association for Enterprise Opportunity's Economic Impact Council and Micro Capital Task Force.

3. Small Business Majority is a national small business advocacy organization headquartered in California, founded and run by small business owners to ensure America's entrepreneurs are a key part of an inclusive, equitable, and diverse economy. We actively engage small business owners and policymakers in support of public policy solutions, and deliver information and resources to entrepreneurs that promote small business growth and drive a strong, sustainable job-creating economy. Our extensive scientific opinion polling, focus groups, and economic research help us educate and inform policymakers, the media, and other stakeholders about key issues impacting small businesses and freelancers, including healthcare, access to capital, taxes, retirement, paid leave, and other workforce issues.

4. On October 13, 2017 Small Business Majority released the results of a nationwide survey of women small business owners titled "Women Small Business Owners Say Access to

Birth Control is Important to their Success, Support Continued Coverage." A true and correct copy of these results is attached as Exhibit A. Findings from the survey include:

- 71 percent of respondents believe health insurance issuers should be required to include birth control coverage in their health plans, and 54 percent strongly agree. This is an agreement that crosses all demographic sub-groups, with majorities across political, racial, religious and age lines agreeing that issuers should be required to include birth control coverage in health plans.
- 79 percent of respondents agree that contraceptive coverage is important for women's economic empowerment and well being. The same percentage believes we need to ensure all women have access to affordable reproductive healthcare as a basic economic issue.
- 56 percent of respondents agree that birth control access was beneficial for their own individual pursuit of education and business ownership, and 52 percent believe this access impacts their ability to grow their business.

5. Based on these survey results and our experience dealing with the needs of small businesses on a daily basis, Small Business Majority believes it is "important for lawmakers to understand that women entrepreneurs believe access to reproductive health is a key component of healthcare, and that access to comprehensive health coverage, including birth control, is critical to ensuring their and their employees' economic wellbeing. Access to contraceptive coverage promotes the financial stability of female entrepreneurs and their employees, both of which are ultimately important for an entrepreneur's bottom line, as recruiting and retaining a healthy and productive workforce is a critical aspect of running a successful small business."

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on October 16, 2017, in Sausalito, California.

John Arensmeyer
Founder & CEO
Small Business Majority

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XAVIER BECERRA, SBN 118517
Attorney General of California
JULIE WENG-GUTIERREZ, SBN 179277
Senior Assistant Attorney General
R. MATTHEW WISE, SBN 238485
KARLI EISENBERG, SBN 281923
MICHELE L. WONG, SBN 167176
Deputy Attorneys General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-6046
Fax: (916) 324-8853
E-mail: Matthew.Wise@doj.ca.gov
Attorneys for Plaintiff State of California, by and through Attorney General Xavier Becerra

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA,

Plaintiff,

v.

DON J. WRIGHT, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF LABOR; U.S. DEPARTMENT OF LABOR; STEVEN MNUCHIN, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF THE TREASURY; U.S. DEPARTMENT OF THE TREASURY; DOES 1-100,

Defendants.

4:17-cv-05783-KAW

DECLARATION OF JENNA TOSH IN SUPPORT OF STATE OF CALIFORNIA'S MOTION FOR PRELIMINARY INJUNCTION

I, Jenna Tosh, Ph.D., declare and state as follows:

1. I am the President & CEO for Planned Parenthood California Central Coast (PPCCC) and Chair of the Board of California Planned Parenthood Education Fund, the state-wide entity that represents the seven California Planned Parenthood affiliates. I have been the President & CEO of PPCCC since 2015 and recently began serving as the Chair of the Board of PPAC. Before joining PPCCC in February 2015, I was the President & CEO of Planned Parenthood of Greater Orlando, where I had previously served as Director of Education and Advocacy since approximately 2005.

2. This declaration is based on my personal knowledge, my review of PPAC's business records, and the knowledge I have acquired in the course of my twelve years of service and duties at Planned Parenthood. If called and sworn as a witness, I could and would testify competently to the information in this declaration.

3. The California Planned Parenthood Education Fund (CPPEF) and its sister organization, Planned Parenthood Affiliates of California (collectively, PPAC), represent California's seven separately incorporated Planned Parenthood affiliates. The mission of the Planned Parenthood organizations in California is to provide comprehensive reproductive health care services, to provide educational programs relating to reproductive and sexual health and to advocate for public policies to ensure access to health services, including safe, legal abortion. Collectively, the California affiliates operate 115 health centers and serve more than 750,000 patients each year. 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.

4. As discussed more fully below, the two interim final rules that the U.S. Health and Human Services Department, in conjunction with the U.S. Department of Labor and U.S. Department of Treasury, issued on October 6, 2017 (IFRs) would have devastating consequences for the women in California who rely on Planned Parenthood for a variety of reproductive health and family planning care. The IFRs would also have a devastating impact on the State of California, which reimburses Planned Parenthood affiliates for those patients' care through a combination of state and federal funding. Planned Parenthood serves more than 750,000 patients

annually, almost 30% of the California women of reproductive age who are in need of publicly funded family planning services. Eighty-six percent (86%) of those patients receive care through programs reimbursed by the State.

I. EMPLOYMENT AND EDUCATION BACKGROUND

5. I received my BA in Political Science from the University of Florida, magna cum laude, in 2004. I then earned my Masters in Political Science from the University of 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 Ph.D. 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."

6. 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 & Advocacy from 2006 to 2009. In 2012, I was appointed President & CEO of Planned Parenthood of Greater Orlando. I served in that capacity until becoming President & CEO of Planned Parenthood California Central Coast (PPCCC) in February 2015.

7. PPCCC is the Planned Parenthood affiliate for Santa Barbara, Ventura, and San Luis Obispo counties. It provides services to approximately 34,000 patients annually over three counties with five clinic locations. The care for 74% of our patients is reimbursed through the State's Medi-Cal program.

II. ORGANIZATION AND AFFILIATION

8. PPAC is a 501(c)(4) organization that leads the state-wide public policy and advocacy work on behalf of the seven separately incorporated Planned Parenthood affiliates in California. PPAC was the first state public affairs office of Planned Parenthood Federation of America (PPFA).

9. PPAC's mission is to create a personally and politically safe climate in which individuals have universal and unfettered access to sexual and reproductive health service and are free to follow their own beliefs, values and moral code when making decisions about these

services.

10. California Planned Parenthood Education Fund (CPPEF) is a California non-profit 501(c)(3) organization that works to provide reproductive and complementary health care services in settings that preserve and protect the essential privacy and rights of each individual.

11. CPPEF is a membership organization consisting of the seven California Planned Parenthood affiliates. Each affiliate is a separately incorporated non-profit organization with its own Board of Directors, budget, management and staff. Each affiliate is responsible for delivering health care services in a distinct geographic region. These affiliates provide sexual education and reproductive health care across California through 115 separate health centers. In 2016, these affiliates served almost 750,000 patients; 85.8% were at or below 200% of the federal poverty line. The California Planned Parenthood affiliates provided contraception to nearly 631,000 patients, conducted 1 million pregnancy tests, and provided 1.5 million tests and treatments of sexually transmitted infections. They also provided sexual health education programs to over 207,000 youth in California.

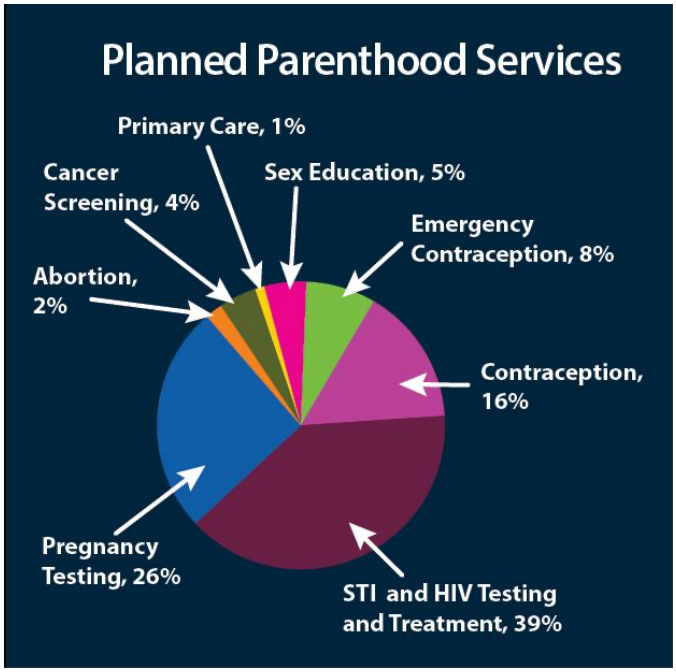
III. PLANNED PARENTHOOD'S ROLE IN PROMOTING PUBLIC HEALTH IN CALIFORNIA

12. Planned Parenthood operates 115 health centers in California. They span from the northwest corner of the State in Eureka to the southeast corner near the Mexican border in El Centro. Health centers can be found in the major metropolitan areas of Los Angeles (25 altogether), San Diego, San Jose, San Francisco, Oakland and Sacramento. My affiliate, PPCCC, operates five health centers along the Central Coast. Planned Parenthood Mar Monte operates twelve clinics through-out the Central Valley. A number of affiliates operate health centers in the more rural parts of the State, such as Antelope Valley, Victorville, Ukiah, and Redding.

13. Planned Parenthood provides primarily reproductive health care services as a "one stop shop." This means that a patient is able to get an office visit, most relevant lab tests and any needed drugs or supplies at one location without having to travel to a pharmacy or lab testing facility. This service is particularly important for the low income patients we serve who usually do not have the time, money or resources to take additional time off of work or school or the ability to arrange for childcare. It also increases the likelihood that patients will get their tests

completed and take the drugs they are prescribed.

14. All affiliates offer education and counseling on reproductive health for both men and women; the provision of birth control, including emergency contraception; testing and treatment of HIV, gonorrhea, chlamydia and the HPV virus; pregnancy testing and services; breast and cervical cancer screenings; and safe and legal abortion. In addition, three affiliates offer PEP and PReP for HIV prevention. Two offer trans-health services for transgender patients. Two offer primary care. Five do prenatal screenings and referrals. Two provide prenatal care. And five do female and male sterilizations (Essure and vasectomies). This is an overview of the primary services we offer in California:



15. In 2016, Planned Parenthood saw over 748,000 patients in 1.4 million appointments. In 2016, we served California with:

a. Contraception to nearly 631,000 patients

b. Nearly 322,000 emergency contraception tests

c. 450,000 pregnancy tests

d. Over 78,000 cervical cancer screenings

e. Almost 80,000 breast cancer exams

f. Over 1.5 million tests and treatments for sexually transmitted infections

g. Sexual health education programs reaching 207,000 youth.

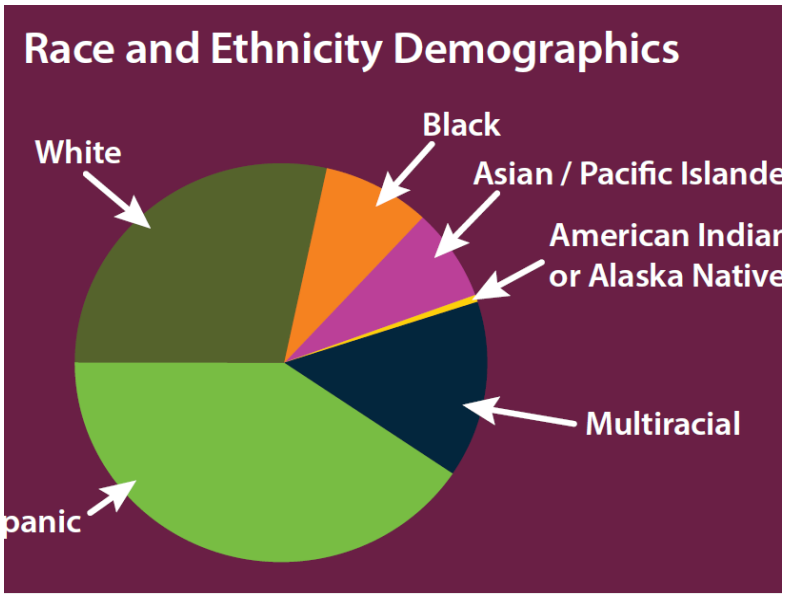
16. To give a sense of the volume that Planned Parenthood handles, the Los Angeles affiliate alone sees more than 1000 patients a day and fields more than 3000 calls at its call center.

17. Planned Parenthood primarily serves low income patients in California who have limited access to health care services.

a. Approximately eighty-eight percent (88%) of our patients are women, almost all of those are in the prime reproductive age range of 18 to 39;

b. Eighty-six percent (85.8%) are below 200% of the federal poverty level ($24,120 for one person). Of those, 31% are below 138% of the federal poverty level ($16,643 for one person);

c. The demographics of our patients roughly mirror the demographics of California: 25% are white, 36.7% are Hispanic, 8.4% Black; 8% Asian/Pacific Islander, 2.2% multi-racial and 20% other or unknown:



d. Many of our patients are immigrants, and some are undocumented. Many speak languages other than English. All health centers have telephone access to translators in 250 languages. As one example, Planned Parenthood of Orange San

Bernardino Counties reported this year that they had provided services in 48 different languages.

e. We also serve a number of special-needs populations, including people with physical, mental or other social challenges; migrant workers; homeless people; patients with limited English skills; and lesbian, gay, bisexual, transgender people. We have implemented a variety of programs to extend access to these populations and to assure delivery of care that is culturally sensitive and appropriate.

18. Planned Parenthood operates its health centers in many medically underserved areas.

a. For example, just last year, Planned Parenthood Pacific Southwest opened a health center in El Centro in Imperial County near the Mexican Border. El Centro and Imperial County have high levels of poverty and limited employment opportunities. The unemployment rate is the second highest in the United States. Two significant issues in that region are the lack of health care providers and effective sexual education programs. According to a 2010 report by the Bixby Center for Global Reproductive Health, less than 35% of Imperial County women in need of publicly funded contraceptive services access them. Imperial County has the second highest teen birth rate in the State: 44.5 teen births per 1000 adolescents, compared to 7 in Marin.

b. As another example. Planned Parenthood Los Angeles operates a health center in Antelope Valley in eastern Los Angeles County, with a 27.3 % poverty rate.

19. Planned Parenthood clinics are staffed with experienced practitioners at multiple levels. We employ physicians, advanced practice clinicians (physicians' assistants, nurse practitioners, certified nurse midwives, registered nurses, licensed midwives) and medical assistants. Each operates within their particular, authorized scope of practice so that health care services are delivered as efficiently and cost-effectively as possible.

20. Patients come to Planned Parenthood for the accurate, nonjudgmental, compassionate and confidential care and information they need and deserve. Providers are

trained to be culturally competent, which is essential in a State with such a diverse patient base.

21. Planned Parenthood affiliates in California also engage in advocacy and public education activities. In 2016, our sexual health education programs reached more than 207,000 youth.

IV. FAMILY PACT AND MEDICAID

22. Approximately 86% of Planned Parenthood's patients receive their health care through Medi-Cal. 44.5% are enrolled in the Family PACT program, described in greater detail below. 9.4% receive their care through Medi-Cal fee-for-service. And 31.9% are enrolled in Medi-Cal managed care. California reimburses Planned Parenthood for the care it provides patients through these programs. Pursuant to California's State Medicaid Plan, the federal government is responsible for covering a portion of the Family PACT and Medi-Cal managed care programs for reproductive health care services. The State of California covers the remainder. For every dollar Planned Parenthood spends on family planning services in California, the federal government contributes 77.49 cents while the State spends 22.51 cents. Medi-Cal is reimbursed 50% by the federal government and 50% by the State of California with the exception of certain services, such as abortion, that are reimbursed 100% by the State.

23. In 1996, California created the Family Planning, Access, Care, and Treatment (Family PACT) program. Family PACT is a reproductive health program for clinical family planning services. It is now part of California's Medi-Cal program. The Family PACT Program is administered by the Department of Health Care Services (DHCS) Office of Family Planning (OFP). DHCS manages the State's Medicaid Program (Medi-Cal) and is responsible for provider enrollment, claims processing and responding to the public's questions regarding these issues. Family PACT delivers services at no cost to over 1.68 million people each year.[1]

24. Family PACT has been a model in delivering family planning services to low-income individuals. In the past twenty-five years, California's Family PACT program has been responsible for causing:

[1] Bixby Center for Global Reproductive Health, University of California San Francisco, *Family PACT Program Report Fiscal Year 2013-2014*, at 5 (Bixby Annual Report).

- the rates of unintended pregnancy and unplanned births to decline 82%[2]
- the teen birth rate to decline by 71%[3]
- the number of abortions to fall by 50%.

25. Decreases in the rate of unintended pregnancies and abortion over the long term result in a corresponding decrease in the risk of maternal mortality, adverse child health outcomes, behavioral problems in children, and negative psychological outcomes associated with unintended pregnancies for both mothers and children. Avoiding unintended pregnancies also helps women to delay childbearing and pursue additional education, spend additional time in their careers, and have increased earning power over the long term.[4]

26. Family planning, and the consistent use of contraception, is the most cost effective way to reduce unintended pregnancies.[5] For every 1000 unintended pregnancies, 42% will result in live births, 13% in miscarriages, and 45% in abortion.[6] Thus, reducing unintended pregnancies reduces expenses due to fewer delivery, miscarriage or abortion costs.

27. In California, 64% of unplanned births are paid for by the State.[7] The California Health Benefits Review Program recently estimated that the average cost of an unintended pregnancy is $15,364.[8] The average cost for an office visit for a miscarriage is $4,249, and the average cost of an abortion in the insured population is $2,357.[9]

28. There are additional public sector costs stemming from unintended pregnancy. Low income pregnant women can qualify for several public health and social programs which

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[2] Guttmacher Institute, *State Facts on Publicly Funded Family Planning Services: California* (Sept. 2016), https://www.guttmacher.org/fact-sheet/state-facts-publicly-funded-family-planning-services-california

[3] *Id.*

[4] California Health Benefits Review Program, *Analysis of California Senate Bill (SB) 999 Contraceptives: Annual Supply,* A Report to the 2015-2016 California State Legislature, at I (March 28, 2016, revised May 3, 2016)(hereinafter CHBRP Contraceptive Report).

[5] *Id.* at 15, 22; Bixby Center for Global Reproductive Health, UCSF, *Cost-Benefit Analysis of the California Family PACT Program for Calendar Year 2007,* at 6-7, 20 (April 2010).

[6] CHBRP Contraceptive Report, at 30, *citing* Kost K., *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends since 2002 (*New York 2015).

[7] Guttmacher Institute, *State Facts About Unintended Pregnancy: California* (Sept. 2016), https://www.guttmacher.org/fact-sheet/state-facts-unintended-pregnancy-california

[8] CHBRP Contraceptive Report, at 10, 30.

[9] *Id.* at 30.

provide free or low-cost services before and after delivery for themselves and their children. One study, done over a decade ago, found that each unintended pregnancy cost the public sector $6,557 in medical, welfare and other social service costs for a woman and child up to age two.[10] The savings were $14,111 from conception to age five.[11] The State's share of these costs is 33.1% and local government's share is 0.6% from conception to age two. For conception to age five, the State's share is 33.5% and local 0.3%.[12]

29. Family PACT clients are female and male residents of California with a family income at or below 200 percent of the federal poverty level, no other source of family planning coverage, and a medical necessity for family planning services. Family PACT serves 1.1 million income eligible men and women of childbearing age through a network of 2,200 public and private providers. Planned Parenthood provides more than 40% of the family planning visits that are reimbursed by Family PACT in California. In 31% of California's counties, Planned Parenthood health centers serve the majority of patients receiving publicly funded family planning.

30. Another critical component of the Family PACT program is the detection and treatment of sexually transmitted infections (STIs). 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 their associated costs. In FY 2013-2014, the last year statistics are available, 3.4 million STI tests were reimbursed under the Family PACT program.[13] Planned Parenthood performed 1.5 STI tests in California in 2016.

V. New IFRs

31. I have reviewed and am familiar with the new contraceptive coverage IFRs, 2017-21851 and 2017-21852. Under them, any employer that claims a religious or moral objection to providing contraceptive coverage would be exempt. In addition, the IFRs remove the mandatory

[10] Bixby Center for Global Reproductive Health, UCSF, *Cost-Benefit Analysis of the California Family PACT Program for Calendar Year 2007,* at 20 (April 2010).
[11] *Id.*
[12] *Id.* at 21.
[13] *Id.* at 26.

accommodation that women who were no longer able to obtain birth control through their employer could take advantage of to ensure continued contraceptive coverage. These expanded exemptions, together, would effectively make contraceptive coverage optional.

32. Although California's Contraceptive Coverage Equity Act, enacted in 2014, requires private health insurers and Medi-Cal to provide "no cost" contraceptive coverage, self-insured plans are governed by the Employee Retirement Income Security Act (ERISA), not state law. Over six million Californians have self-insured plans and could be affected by their employers' decisions to no longer fund contraceptive coverage.

33. After considering this change in the law and based on my experience in public health, I believe that of the California women who lose coverage under the IFRs, many who are income-eligible—those whose incomes are at or under 200% and are not covered under Medi-Cal—will enroll in Family PACT and seek services from Planned Parenthood. This may be particularly true of younger patients who currently receive insurance through their parents. Almost half of our patients in California (46.81%) are younger than 25. If their parents' insurance no longer covers contraceptive care, there is a high likelihood they will come to Planned Parenthood and qualify for Family PACT.

34. It is estimated that the average reimbursement per Family PACT client is $333.[14] Of this, the State is responsible, on average, for $74.96. Thus, the State will have added costs to reimburse Planned Parenthood for every new Family PACT patient who previously received contraceptive coverage through her employer.

35. I also believe that California will see an increase in unintended pregnancies as a result of the IFRs. Those women who do not qualify for Family PACT may not get contraception. Research suggests that the rate of unintended pregnancy among those who are not suing using contraception is 45%.[15] Because 64% of births in California are paid for by the State, the State will have increased costs shouldering the costs of delivery. For those women with

[14] Bixby Annual Report, at 6.

[15] CHBRP Birth Control Report, at 22, *citing* Finer LB, Zolna MR, Declines in Unintended Pregnancy in the United States, 2008-2011. *New England Journal of Medicine* 374(9): 843-852 (2016).

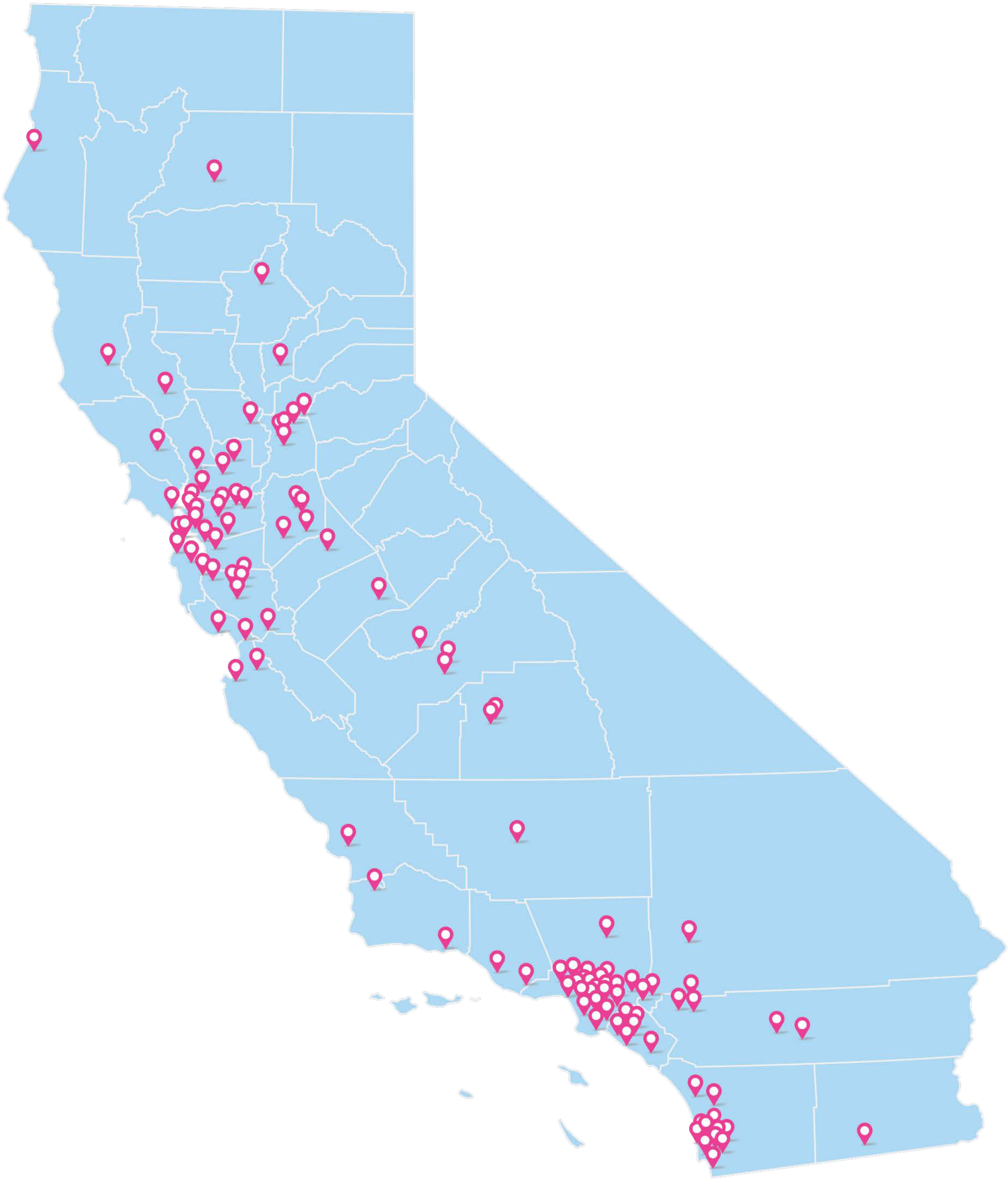
unintended pregnancies who choose abortion, roughly 45%, the State may also have increased costs as its Medi-Cal program covers 100% of the costs of abortion for those whose income is 138% or less of the federal poverty limit. Finally, women who do not qualify for Family PACT may opt against the most effective forms of birth control, which are more expensive. As a result, they will be at a higher risk of unintended pregnancy.

36. Finally, I anticipate that the California affiliates will have to increase charitable contributions to our assistance funds to help insured patients with high co-pays or deductibles, or who have lost coverage for contraception, afford birth control.

I declare under penalty of perjury that the foregoing is correct and that this declaration is executed on 7th day of October, 2017, in Santa Barbara, California.

Jenna Tosh
President & CEO
Planned Parenthood California Central Coast

Exhibit A



XAVIER BECERRA, SBN 118517
Attorney General of California
JULIE WENG-GUTIERREZ, SBN 179277
Senior Assistant Attorney General
R. MATTHEW WISE, SBN 238485
KARLI EISENBERG, SBN 281923
MICHELE L. WONG, SBN 167176
Deputy Attorneys General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-6046
Fax: (916) 324-8853
E-mail: Matthew.Wise@doj.ca.gov
Attorneys for Plaintiff State of California, by and through Attorney General Xavier Becerra
[Additional counsel listed on next page]

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA; STATE OF NEW YORK; STATE OF DELAWARE; COMMONWEALTH OF VIRGINIA, BY AND THROUGH ATTORNEY GENERAL MARK R. HERRING,

Plaintiffs,

v.

DON J. WRIGHT, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF LABOR; U.S. DEPARTMENT OF LABOR; STEVEN MNUCHIN, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF THE TREASURY; U.S. DEPARTMENT OF THE TREASURY; DOES 1-100,

Defendants.

4:17-cv-005783

DECLARATION OF MASSEY WHORLEY IN SUPPORT OF THE COMMONWEALTH OF VIRGINIA'S MOTION FOR PRELIMINARY INJUNCTION

ATTORNEYS FOR ADDITIONAL PLAINTIFFS

MATTHEW P. DENN
Attorney General of Delaware
AARON R. GOLDSTEIN*
State Solicitor
LAKRESHA S ROBERTS*
Chief Deputy Attorney General
ILONA KIRSHON*
Deputy Attorney General
Delaware Department of Justice
801 N. French Street
Wilmington, DE 19801

ERIC T. SCHNEIDERMAN
Attorney General of New York
LISA LANDAU*
Bureau Chief, Health Care Bureau
SARA MARK*
Special Counsel
ELIZABETH CHESLER*
Special Counsel
120 Broadway, 25th Floor
New York, NY 10271

MARK R. HERRING
Attorney General of Virginia
SAMUEL T. TOWELL*
Deputy Attorney General
202 North Ninth Street
Richmond, VA 23219

* Pro hac vice application forthcoming

I, Massey Whorley declare:

1. I am over the age of 18 and competent to make this declaration.

2. I am the Senior Policy Advisor to Governor Terence R. McAuliffe in the Office of the Governor of Virginia. I have served in this capacity since September of 2016. Prior to my current position, I was a Senior Policy Analyst at the Commonwealth Institute for Fiscal Analysis, a nonpartisan organization that provides analyses of fiscal and economic policies and their implications for Virginians, especially low- and middle-income residents, where I managed the Health Care and Tax portfolios.

3. Plan First is Virginia's limited benefit family planning program that covers all birth control methods provided by a clinician and some birth control methods obtained with a prescription, such as contraceptive rings, patches, birth control pills, and diaphragms.

4. In general, women in families with income below 200 percent of the applicable federal poverty guideline are eligible for Plan First.

5. As of October 1, 2017, 115,895 individuals were enrolled in Plan First per information compiled by the Department of Medical Assistance Services (DMAS).

6. Total spend on Plan First in State Fiscal Year 2017 (July 1, 2016 through June 30, 2017) was $7,142,414, according to DMAS records.

7. According to DMAS records, two of the top five providers in fiscal year 2017 were the Medical College of Virginia and the University of Virginia Hospital systems, both of which are part of state-supported health systems.

8. Virginia does not have a contraceptive equity law. That is, there is no state requirement that insurance plans offer contraceptive coverage to women at zero cost to them.

9. I am familiar with the interim final rules that the U.S. Health and Human Services Department, in conjunction with the U.S. Department of Labor and U.S. Department of Treasury, issued on October 6, 2017 (IFRs). Under the IFRs, any employer could claim a religious or moral objection to providing contraceptive coverage and leave their employees without free

contraceptive coverage. This expanded exemption would effectively make contraceptive coverage optional.

10. Women impacted by the IFRs who are eligible for Plan First may be expected to enroll in Plan First, resulting in an increase in enrollees in this state-supported program which would have a corresponding fiscal impact.

11. State providers, such as the Medical College of Virginia Hospital and the University of Virginia Hospital, do not recover 100 percent of the cost of the care they provide under Plan First. Accordingly, an increase in women seeking services from these two hospital systems under Plan First will have an additional impact on Virginia's financial obligations.

[REMAINDER OF PAGE INTENTIONALLY LEFT BLANK]

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

Executed on October 10, 2017, in Richmond, Virginia.

MASSEY WHORLEY
Senior Policy Advisor, Office of the Governor

XAVIER BECERRA, SBN 118517
Attorney General of California
JULIE WENG-GUTIERREZ, SBN 179277
Senior Assistant Attorney General
R. MATTHEW WISE, SBN 238485
KARLI EISENBERG, SBN 281923
MICHELE L. WONG, SBN 167176
Deputy Attorneys General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7913
Fax: (916) 324-8853
E-mail: Karli.Eisenberg@doj.ca.gov
Attorneys for Plaintiff the State of California

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

THE STATE OF CALIFORNIA; THE STATE OF DELAWARE; THE STATE OF MARYLAND; THE STATE OF NEW YORK; THE COMMONWEALTH OF VIRGINIA,

Plaintiffs,

v.

ERIC D. HARGAN, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF LABOR; U.S. DEPARTMENT OF LABOR; STEVEN MNUCHIN, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF THE TREASURY; U.S. DEPARTMENT OF THE TREASURY; DOES 1-100,

Defendants.

4:17-cv-05783-HSG

DECLARATION OF JONATHAN WERBERG IN SUPPORT OF PLAINTIFF STATES' MOTION FOR PRELIMINARY INJUNCTION

I, Jonathan Werberg, declare under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the following is true and correct:

1. I have served as the Senior Data Scientist in Department of Research and Analytics at the Office of the Attorney General for the State of New York ("OAG") since May 2015. In this capacity, I assist and support in a wide variety of investigations and cases, including several ongoing investigations related to health and health care access. I am frequently called upon to analyze public and private datasets to quantify the impacts of particular policies. Prior to this position, I spent ten years at 1199 SEIU United Healthcare Workers East, a union of health care workers based in New York with over 400,000 members. I served in various research and analysis capacities, including the final three years as the Research Director of a department with 20 staff. In those roles, I conducted and oversaw dozens of analyses of health care policies. I am very familiar with health care, health insurance and demographic data. I am a 2003 graduate of the Massachusetts Institute of Technology with a Bachelors of Science degree in Urban Planning. I submit this declaration in support of the Complaint in the above-captioned lawsuit challenging the Defendants' Interim Final Rules (IFRs).

2. Based on publicly available data, there are approximately 1.16 ***million*** women in New York State who are currently covered by self-funded employer plans.

3. This number is based on the following analysis: According to the U.S. Census Bureau, 2,540,725 women of child-bearing age, defined as 12 to 44-years old,

reside in New York State and possess employer-based health insurance.[1] Approximately 2,154,535 women in New York State with health insurance work in the private sector.[2] According to the most recent estimates from HHS' Medical Expenditure Panel Survey, approximately 54 percent of private-sector employees in New York are enrolled in self-insured plans.[3]

4. Thus, considering only women of child-bearing age, and not spouses or daughters of other insureds, the IFRs could impact up to approximately 1.16 million women in New York State.

5. There are a number of employers in New York State that have been identified to me as likely to use the exemptions provided by the IFRs because of their involvement in previous litigation challenging religious exemptions to the federal contraceptive coverage mandate. I have looked at information about these three employers to estimate the number of New York workers employed by each.

6. Hobby Lobby Stores, Inc. is a for-profit national arts and crafts store chain with 28,000 employees across the United States. In New York State, Hobby Lobby has twelve store locations and employs approximately 600 people.[4]

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[1] U.S. Census Bureau; American Community Survey, 2011-2013 American Community Survey 3-Year Estimates, Table B27004; generated using American FactFinder; <http://factfinder2.census.gov>; (October 10, 2017).

[2] *See* U.S. Census Bureau; American Community Survey, 2016 American Community Survey 1-Year Estimates, Table S0201; generated using American FactFinder; <http://factfinder2.census.gov>; (October 10, 2017).

[3] Agency for Healthcare Research and Quality. Percent of private-sector enrollees that are enrolled in self-insured plans at establishments that offer health insurance by firm size and State (Table II.B.2.b.1), year 1996-2016: 2016 (July 2017). Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC. (October 10, 2017).

[4] "Hobby Lobby Stores on Forbes Lists" https://www.forbes.com/companies/hobby-lobby-stores/ Accessed November 9, 2017

7. Nyack College, an affiliate of the Christian and Missionary Alliance, is a liberal arts college in New York, with approximately 2,500 students enrolled in its programs; the college employs approximately 1,200 people.[5]

8. The Charles Feinberg Center for Messianic Jewish Studies, an affiliate of Biola University, is a Master of Divinity graduate program in New York. Biola University nationally has approximately 1,000 students.[6]

9. Thus, according to my research and analysis, there will be a substantial number of New York women who may lose health plan coverage for contraceptives as a result of these IFRs.

Executed on November 9, 2017

Jonathan Werberg
Senior Data Scientist
New York State Office of the Attorney General

[5] Nyack College IRS Form 990 for Fiscal Year ending June 30, 2016 available at: http://990.erieri.com/EINS/131740285/131740285_2015_0ddd1e4e.PDF

[6] Fall 2015 enrollment in Biola University's Talbot School of Theology was 1,110 students. Biola Univ. Office of Institutional Research, *Biola University Fall 2015 Enrollment Summary*, BIOLA UNIV. 1, 5 (2015) available at: https://www.biola.edu/institutional-research/reports